

MEDICAL REPRINTS

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M E D I C A L R E P R I N T S

WITH ORIGINAL ESSAYS.

VOLUME IV.

TO

The Members of the Profession

OF

Medicine

IN GREAT BRITAIN, IRELAND, THE BRITISH COLONIES,
AND THE UNITED STATES OF AMERICA,

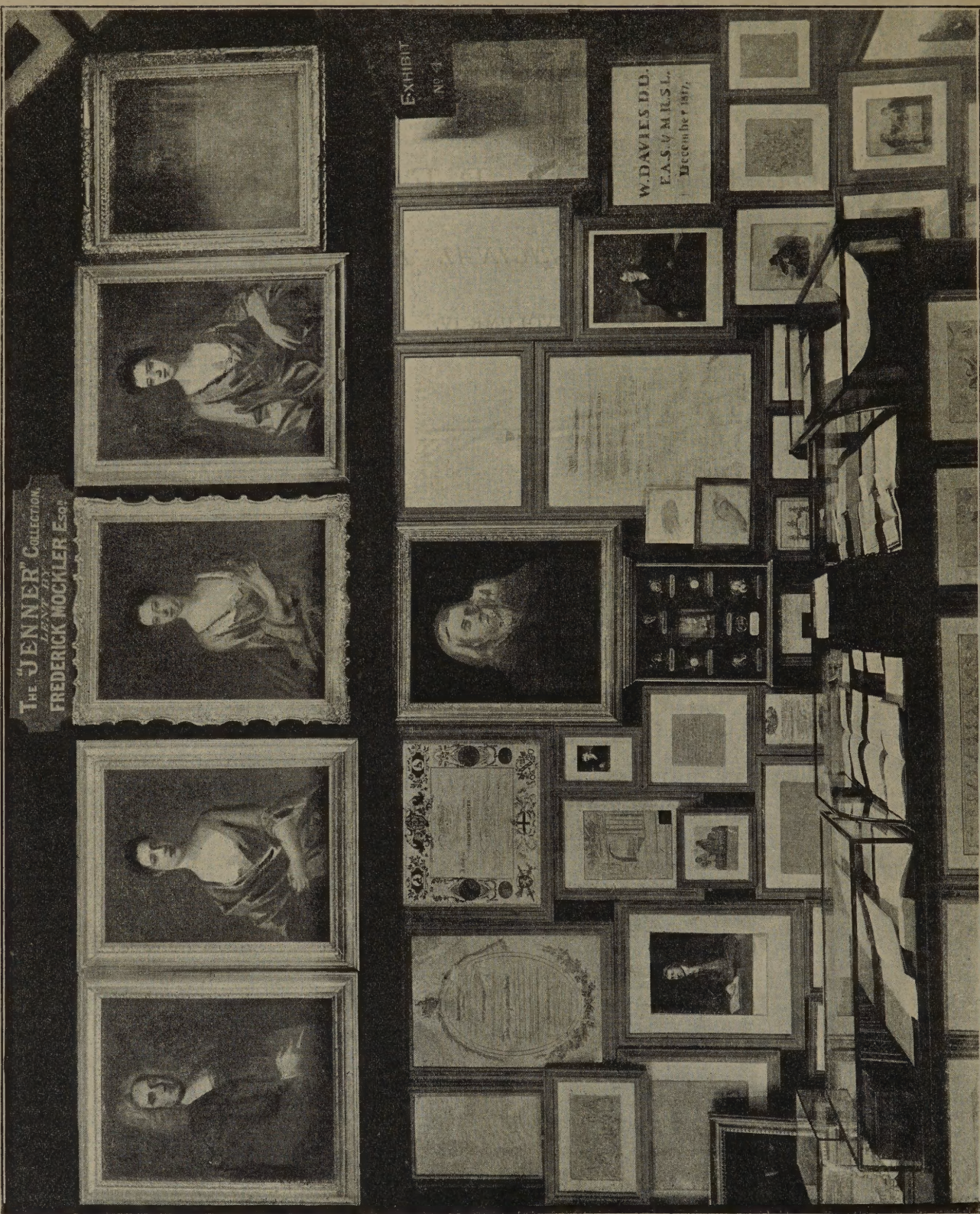
*For whom, and by whom, this journal is produced, and but for whose support
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THIS FOURTH VOLUME

OF

M E D I C A L R E P R I N T S

is most respectfully dedicated.



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MEDICAL REPRINTS

Home, Foreign, and Colonial.

WITH ORIGINAL MEDICAL ESSAYS.

VOLUME IV.

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JOHN MORGAN RICHARDS, 46, HOLBORN VIADUCT, LONDON, E.C.

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MEDICAL REPRINTS

Home, Foreign, and Colonial: with Original Essays.

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[No. 37.]

WERE PROTOPLASMIC REVERSIONS CHECKED BY ALCOHOL?

By WILLIAM H. PEARSE, M.D. Edin., Senior Physician
Plymouth Public Dispensary.

[Reprinted by permission from "The Provincial Medical Journal."]

C. C. D.—, æt. forty-four, married; has three children from seventeen to twenty-four. Fifteen years ago had syphilis and gonorrhœa, from her husband; severe rheumatic fever followed within a year. A mitral bruit resulted, which has remained unchanged since. Several attacks of rheumatic fever have occurred since the first one. She also is subject to severe catarrhal attacks of both lungs; moist râles develop early, but without dulness on percussion. Six years ago she had hemiplegia of right side; the side has fairly recovered, but she is subject to "lightning" pains in right big toe. At the time of her hemiplegic attack, there was also severe bronchitis, and an extremely furred tongue. After the hemiplegia, I renewed the hyd. bichlor. and pot. iodid. treatment for two months. Since then, except bronchial attacks every winter, and occasional slight rheumatism, she has kept fairly well; the cardiac bruit has remained unchanged, but in her bronchial and rheumatic attacks the heart becomes extremely rapid and irregular.

In April, 1892, she had a severe bronchial and rheumatic attack; the heart's action was very rapid and could not be counted; constant vomiting lasted for three days. I feared the patient would sink. A blister over the heart was followed by immediate relief of the vomiting, and a quieting of the heart's action. She got well, and spent a month in the country with advantage. No permanent albumen.

On July 14th, 1892, she was quite well; on the 15th had pains in the legs; heart rapid and irregular; and bruit as usual; urine no albumen; tongue dry in centre; thick coat at edges; temp. 102.5°. Salacin gr. xv., tr. aconit. ℥ ij., tr. digitalis ℥ x., every four hours. Blister over cardiac region. 16th: Tongue dry in centre; heart irregular; much sweat; temp. 102°. 17th: Tongue dry in centre; much sweat; temp. 100°. 18th: Temp. 98.4°; tongue moist. 20th: Temp. 99.8°; heart less rapid. 22nd: Temp. 98.4°; heart less rapid; moist râles at left base only; tongue cleaning; pains gone; continued the digitalis and salacin. 26th: Heart quiet; tongue slightly coated; pains in front of thorax and about clavicles; temp. 98.4°. 27th: Temp. 98.4°. 29th: Complained of pains in muscles of legs and arms; no pain in joints; temp. 100.2°; can get no sleep at night; urine for some days has given off ammoniacal smell soon after voided. 30th, 7 p.m.: Heart but slightly irregular; few moist râles at left base; not dull on percussion; tongue dry in centre and dark; edges thickly coated. Expression of countenance prostrate and collapsed. I recognised a distinctly ammoniacal smell from her breath and body. The patient was on the verge of sinking. I ordered a glass of port wine every two hours, a teaspoonful of Warburg's tincture every three hours, and Valentine's meat juice. 31st: Expression of countenance improved; tongue moist; temp., 10 a.m., 101°; temp., 10 p.m., 101.5°.

August 1st: Temp. 99°; heart quiet; tongue cleaning in centre; wine, twelve ounces a day; four drachms of Warburg a day. 2nd: Temp. 98°; tongue clean in centre; a thin coat at edges; wine continued, Warburg continued. 3rd: Tongue perfectly clean; heart natural, but rarely intermittent; takes her food well. The basis of diet throughout was milk.

I began the wine on the evening of the 30th; she drank half a bottle of the best port I could get from 6 p.m. to 10 a.m. the next day. Following the use of the wine and Warburg was a moderately free and increased action of the bowels, the motions being highly offensive.

¹ The acknowledgments of the Editor of MEDICAL REPRINTS are due as well to the author of this article as to the Editor of *The Provincial Medical Journal*.

If there be one lesson in philosophy which more than any other young medical men should make their own, it is that which Bacon taught of the folly of reasoning and concluding from "affirmatives."² In this case, however, the aspect and condition of the patient changed, like a transformation scene, following the use of the wine and Warburg.

Remarks.—After a fortnight's illness of moderately acute rheumatism, and which had in the main passed off, the patient threatened to sink; dry brown tongue; no appetite; ammoniacal smell of body; her protoplasm and vital modes were beginning to pass into that series of changes under which life ceases; her symptoms fundamentally were those common to the later stages of a great variety of "different diseases." It was just and necessary to consider and treat her early stages as rheumatic fever; but in her later stage, it was necessary to cast overboard the limiting influence of nomenclatures and names, and to treat a different condition, viz., a "generic type" of protoplasmic decay; her later condition was in symptoms—and we may fairly hold the hypothesis that it was so in its deeper pathology—just like what is seen in the later stages of all fevers, and in many chronic diseases. In the last stages of many diseases of long standing, a little central drying of the tongue, a little acceleration of the pulse, and heat of the skin, pass in a few days to stupor, small catarrhal râles, and death. My rheumatic patient had obviously reached this state, and I think one is justified in holding the hypothesis, that death was hindered by the wine and Warburg. The bowels had been daily regular throughout her illness, but following the wine and Warburg, they acted more freely, and with extremely offensive odour. Alcohol, to those not accustomed to its use, acts most powerfully on the abdominal viscera, inducing in many a moderate but free action of the bowels. Warburg has its aromatics and aloes.

Two wide hypotheses are advanced in this case. First, that the highly differentiated vito-chemical molecular modes of the patient were, towards the end of her illness, in an unstable and weakened state, and about to revert to conditions incompatible with the continuance of life. Second, that by the influence of alcohol on the nerve protoplasm, such fatal changes were arrested; in fact, I intended to make the patient fully feel the happier influences of wine to the full; I intended to put the patient in a state like to that a man feels when he is "happy" under the influence of good wine. The "happiness" which a man feels when he has well, but moderately, drunk wine, shows heightened powers of mind, feelings, senses, and a general stimulation of the fundamental vital or sexual energy. Such a state is the very reverse of the adynamic modes of "fatigue fever," "typhus," and the allied states which appear at the later stages of so many exhausting diseases, and in this case, at the end of one of many rheumatic attacks. It appeared to me that had the wine and Warburg been delayed a few hours, reversions would have happened incompatible with life. But beyond the use of alcohol in this case, we must not lose sight of the powerful effects of the aromatics, aloes and quinine, of Warburg.

I have ventured to cite this "common case," because it represents a "generic type" of pathological change and symptoms, and because it opens up to view the deepest Forms and Laws of Therapeutics. I hope also that my practice was wise, and in harmony with the great continuity of Nature. We may be entranced with the desire to see truly, and to aid to solve, the Methods of therapeutic action; to see the laws of the reciprocal actions of the intermolecular atomic affinities of the varied albuminoids of protoplasm, and of our remedies; but we are, therefore, not precluded from following Niemeyer, when he says, "I . . . denounced the error of postponing all medical treatment of disease, until our knowledge of the

² " . . . that instance which is the root of all superstition—namely, that to the nature of the mind of all men it is consonant for the affirmative or active to effect more than the negative or privative. So that a few times hitting, or presence, countervails oftentimes failing or absence."—"Advancement of Learning."

ction of medicines, and our insight into pathological processes, should be so far advanced, that means of cure would be self-evident. I pronounced their ideal goal to be unattainable. . . ."³

EARLY DIAGNOSES OF MASTOID DISEASE AND OPERATION, AS A LIFE-SAVING MEASURE, IN THE PREVENTION OF PYÆMIC AND MENINGITIC COMPLICATIONS.

By D. MILTON GREENE, M.D., of Grand Rapids, Mich., Eye, Ear, and Throat Surgeon to St. Mark's and U.B.A. Hospitals; Lecturer on the Eye to the St. Mark's Training School; Lecturer on the Larynx and Hygiene in the Western Michigan College, &c.

[Read in the Section of Laryngology and Otology, at the Forty-third Annual Meeting of the American Medical Association, held at Detroit, Michigan, U.S., 1892.]

ACUTE suppuration of the middle ear is a disease of very common occurrence, and runs its course in many instances without serious complications, ending in recovery. Other cases result in permanent destruction of a part or the whole of the drum membrane; while some result in deafness, chronic suppuration, granulations, polypi, &c.

More serious complications frequently occur, such as suppuration in the mastoid cells, with perforation and pyæmia, cerebral abscess, or meningitis from caries and extension of inflammation.

Such complications occur more frequently, I believe, than has generally been supposed by the medical profession, and I think those who have given any considerable time to the study and treatment of aural disease will bear me out in the assertion.

The general practitioner is not awake to the dangers of this disease, and with a hypodermic of morphia puts the patient to sleep—and the doctor as well—while the true character of the disease is masked, and allowed to pursue its destructive course, resulting frequently in death, which is attributed to some other cause.

That this course of treatment has been confined to the general practitioner, I dare not charge, for I believe many otologists have been too inactive and dilatory in these cases, and prone to palliate and temporise until Nature has done the work or the disease has placed the patient in a hopeless condition, as all statistics go to prove.

While I do not wish to be understood as advocating the too free and indiscriminate use of the drill and chisel in acute suppurative otitis media, I do think we may err as far in the other direction; and I believe that the operation of opening the mastoid should be governed by the same sound surgical principles that govern other surgical operations; that we should not delay the operation until pyæmic or meningitic complications put the patient in a hopeless condition, thereby condemning the operation and operator as well.

In looking over the literature on the subject of mastoid disease, I find no other guide to a diagnosis of pus in the cells than the external signs and symptoms of pain, redness, swelling, and œdema over mastoid, which must be present to justify an operation; notwithstanding the report of a few cases in which perforation, pyæmia, and death followed acute suppuration in the middle ear, without the external signs and symptoms over mastoid.

Much has been written on this subject, but it seems that we should be able to formulate some better guide to an early diagnosis than we now have in medical literature.

Pain, redness, swelling, and œdema over mastoid are not essentially signs of pus in the cells, though they do co-exist in some cases.

Though there may be cases of extension of inflammation from the antrum through the bone to the mastoid periosteum, I believe it is an exception rather than the rule, and that a better explanation is found in direct extension from the middle ear along the periosteum, over mastoid process.

I have seen but few cases with pain, redness, swelling, and œdema over mastoid, that have not been preceded by swelling in the external auditory canal proceeding from the tympanum, and extending over mastoid process as perioritis.

These mastoid signs and symptoms have existed with external abscess where the mastoid cells were opened and no

pus found. Then why could not the converse be true? That suppuration in the mastoid cells following acute suppuration in the middle ear frequently exists will not be disputed; but that it exists without external signs over mastoid, or pain referred to that region, frequently ending the life of its victim, I wish to emphasise by a report of five cases, in all of which a diagnosis was made, and four operations with recovery, one without operation ending in perforation, pyæmia, and death, with autopsy.

I have been able to diagnosticate this condition in many other cases where no operation was performed, some of which recovered, but more of whom died with symptoms of pyæmia—cerebral or meningitic complications, but no autopsy could be obtained.

As the external mastoid signs and symptoms are not pathognomonic of pus in the cells, I think they should not be relied upon as a guide to cell complication.

The lining membrane of the Eustachian tubes, tympanum, and mastoid cells is continuous, forming an irregular cul-de-sac; and when the middle ear is inflamed we might well expect inflammation in the cells of the mastoid, by reason of structural continuity.

I believe that in all cases of acute suppurative otitis media, where pus is discharged from the ear in any considerable quantity, after the drumhead is freely open and the ear has been thoroughly cleansed by irrigation with hot boracic acid solution every two hours, and Politizerisation for two or three days, it must come from an abscess cavity, and could not be secreted by the lining of the tympanum; that when together with offensive discharge there is swelling and bulging in the upper and back of the tympanum, there is pus in the mastoid cells, especially when attended with rise of temperature, and pain in occipital region. When vertigo, restlessness, pain in side of head, or a sense of fullness is present, it strengthens the diagnosis of cell complication, and we are justified in exposing the cells whether external signs and symptoms over mastoid are present or not.

The following five cases were those in which an early diagnosis was made, without external signs and symptoms over mastoid, followed by operation or autopsy.

All cases where pain, tenderness, swelling, and œdema, or any one of them, were present, I have excluded from this report; as well as where a diagnosis was made without the external signs and symptoms, but no operation, the patient afterwards dying with symptoms of pyæmia, meningitis, or cerebral abscess, and no autopsy to settle the question of diagnosis.

Case 1.—Mrs. B., aged 52. No previous disease of ears. July 5th, had severe pain in ear from taking cold. I opened drumhead twelve hours after onset, muco-purulent discharge but little; temperature 100. Afterward temperature ranged from 100 to 101 until the fifth day, when it suddenly rose to 104.2; pulse 120. Discharge free until morning of the 5th, but not much during that day.

Saw her at six o'clock p.m.; temperature 104.2; says she feels pain in legs and arms more than elsewhere; no pain, redness, or œdema, or tenderness in mastoid region. Swelling and bulging from upper and back of tympanum. No swelling in external auditory canal. Membrana tympani open at back part over one half its entire size. Tympanum full of thick, offensive pus. Opened mastoid, and found cells full of pus.

Case recovered after three weeks of temperature fluctuating from 98.8 to 100. Hearing in affected ear impaired.

Case 2.—Mrs. S. V., age 24. No previous ear disease. Took cold in right ear, April 2nd. Had ear-ache during night, and until noon of next day, when drum membrane ruptured; saw her soon after; there was some discharge of pus and mucus. Temperature 101, but soon went lower, and remained below that point until the seventh day, when with a chill the temperature went up to 104.6; pulse 110. Quantity of pus diminished, but still quite considerable. Little pain in occipital region. Had chills during high temperature. Can hear but little in left (affected) ear. Feels languid and nauseated. No œdema, pain, or other external evidences over mastoid. No swelling in external auditory canal. Membrana tympani nearly all gone. Swelling and bulging from upper and back of tympanum. Thick pus fills the canal.

Opened mastoid, found about half a dram of pus, in antrum. Case recovered in about five weeks, after quite profuse sweating for some days. Hearing for voice good.

Case 3.—Miss M., age 21. Took severe cold by riding horseback in a cold wind. Had pain in left ear that had been previously affected. Temperature 101, which under treatment went down to 99.4, and remained until the fifth day at 4 a.m., when it suddenly rose to 104. At 10 a.m., 105, with chill and

³ "Text Book of Practical Medicine," 7th edition, 1883; by Dr. Felix von Niemeyer, p. vi.

pain all over body, and some headache on left side. No pain or swelling over mastoid. No tenderness on pressure.

Operated at 11 a.m., and found cells full of gelatinous exudate and thick pus. Free discharge of pus the next day.

Patient recovered in five weeks. Hearing about as before the attack.

Case 4.—Mr. D. C. W., age 58; white; American. Saw this case by kindness of Dr. R. H. Spencer. Never had trouble with ears. Had always been healthy. Took a severe cold Tuesday (seven days previous), had chills and fever. Had frequent chilly sensations. Thursday, had sense of heat and fulness in left side of head. Friday night, went to blow his nose, and felt something give way in left ear, after which had some pain in ear, and at night had bloody discharge from ear. Dr. S. was called. Temperature 102.4, pulse 80, and severe pain. Membrane ruptured during night, and pain ceased. Felt well Saturday and Sunday. Temperature 99.

Monday morning at 4 a.m. had severe pain at back and top of head, which was "dull and heavy," was dizzy. No pain, redness, swelling, or œdema over mastoid, no tenderness on pressure. Drum-membrane open two-thirds its size.

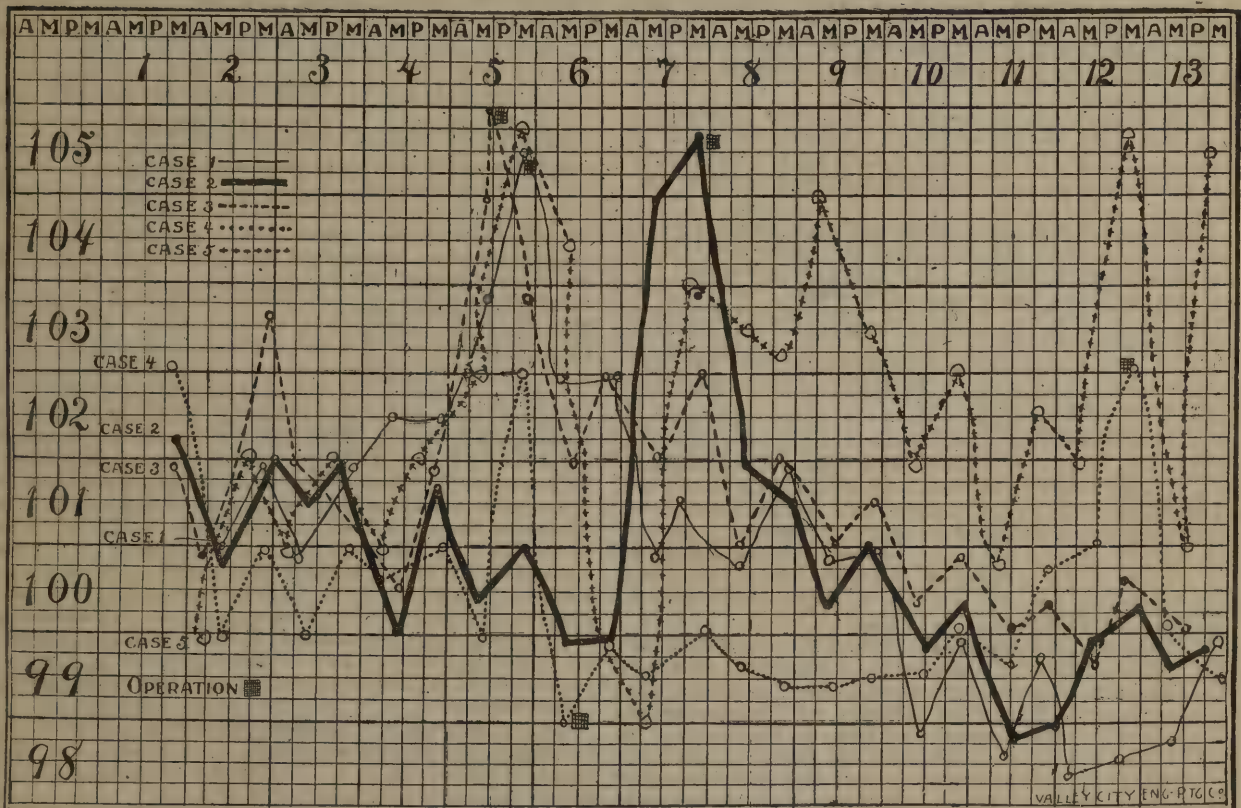
Patient feels well. Discharge free from wound, little from ear. Convalescing.

Case 5.—Mrs. —, age 42. Was called to see this case in consultation with two of our local surgeons, on the tenth day of illness, and got the following history.

Had earache. Drum membrane was opened on second day, and some pus escaped. The case seemed to be doing well until the fifth day, when patient had a chill, and temperature of 104.8. I found auditory canal and tympanum full of pus. Swelling in right ear, and bulging at upper and back of tympanum, looks dark. Headache. No swelling or pain over mastoid. No swelling in external auditory canal. Temperature 102. Diagnosed suppuration in mastoid cells, and advised operation; but as the other physicians did not agree with me in diagnosis no operation was done.

About a week later was called in consultation with three surgeons with same result as before. Dr. George E. Frothingham saw the case three days later, but in absence of external mastoid signs and symptoms, was of opinion that there was not suppuration in cells, but that pus had entered the jugular vein from lower part of tympanum.

I still believed if perforation had occurred, it was from the



TEMPERATURE CHART OF DR. GREENE'S FIVE CASES.

Swelling at upper and back part of tympanum, is bulging, and looks dark and livid. No swelling in external auditory canal. Pus was flowing freely. Tongue coated and dry. Temperature 99.6; pulse 70. Nauseated and looks haggard and pinched. Ear had been irrigated thoroughly every two hours, but was soon full of pus, even in an hour or less. Odour offensive. Was there at 6 p.m., and diagnosed suppuration in mastoid cells, and advised operating the next morning. Felt so much better the next morning that he did not go to the hospital. Discharge less, temperature 102 at 5 p.m. Aches all over, feels chills "running up and down his back." Wants the operation.

Was taken to the hospital, and, assisted by Drs. Graves and Spencer, I opened the mastoid cells with chisel. When first shaving was removed the lining of cells appeared looking livid, the same as swelling in tympanum.

Pus escaped with great force when next shaving was removed. Temperature next morning 98, and remained below 100 for a week, when it went up to 102.4 during day. Again gave chloroform and dug out the cells freely; found some pus. Temperature next morning 99, evening 98.4, and has never reached 100 since.

mastoid cells. No operation was done, and after fifty-one days the case died from metastatic abscesses following pyæmia.

An autopsy revealed perforation into lateral sinus, and a clot three-fourths of an inch long lying back of petros portion.

The viscera of body were in healthy condition.

In conclusion would say that, in the five cases just reported, the treatment has been the most thorough in applying leeches, dry heat, blisters, &c., and in the first four quinine had been given freely. No morphia or other analgesic was given after the first day.

From a series of cases I have formed the following conclusions:

1. That in acute suppurative otitis media, with the drum head freely open—if after two or three days' treatment by thorough irrigation with hot boracic acid solution every two hours, and the tube and tympanum cleared by Politzerisation pus continues to flow so that the canal is filled in an hour or two, or saturates a plug of absorbent cotton, and attended with rise of temperature and chills, without other assignable cause, with swelling and bulging of membrane in upper and back of tympanum, with no swelling from above pointing down-

ward, and no swelling below pointing upward, there is pus in the mastoid cells, and an operation is indicated and justifiable for the safety of the patient. For, as Sir William Wild said a half century ago, "When after the first gush of pus following opening the drum membrane, it continues to flow in any considerable quantity, it must come from a pus cavity, and could not be secreted in the tympanum." (When the above-mentioned signs and symptoms were present, I found pus in the cells when opened.)

2. That there is no more reason for delaying mastoid operations, when pus evidently exists in the cells, than for the surgeon to delay operation in suppurative appendicitis, or the gynaecologist in pelvic abscess.

3. That the operation of opening a mastoid abscess is not more dangerous to life than opening other abscesses.

4. That if no pus is found in mastoid, it heals quickly, and no harm results, but if there is pus or extreme congestion the operation does good, and may save life.

5. That the probability of death from opening healthy mastoid cells is not so great as the probability of pus existing in the cells in cases of acute suppurative otitis media, where the signs and symptoms already mentioned exist.

6. If pus exists in the cells it is a sound surgical principle that it should be removed before it has caused disease of contiguous structures.

7. That when death occurs after mastoid operations, it is from the disease for which the operation was done, and not due to the operation.

8. That suppuration in the cells with early suppurative mastoid periostitis, is not as dangerous to life as where the latter does not exist, for such concomitant tends to soften the dense external bone and favours spontaneous external perforation.

9. That when swelling and tenderness in the auditory canal are extreme, so that an examination of the middle ear is difficult or impossible, it should be done under an anæsthetic.

10. That in acute suppurative otitis media, a rise of temperature to 104 or 105, with chills or rigors, does not contraindicate opening the cells.

11. That chisels are the best instruments with which to open the mastoid, commencing at the tip of the process, and cutting upward and forward.

PERFORATION OF THE LATERAL SINUS.

While using Hamilton's bur-drill in opening the mastoid cells, at a point about a half inch back of, and on a level with, the external auditory canal, I opened into the lateral sinus at a depth of about one eighth of an inch. There was a gush of blood, which I stopped by placing a finger over the drill-hole, until I could secure a strip of bichloride gauze; this was packed firmly into the drill-hole, and a compress and bandage applied and left undisturbed for two days.

I then removed dressings, and no hæmorrhage occurred. As no pus had been reached in the first operation, I packed the drill-hole with equal parts of boracic acid and iodoform, and again proceeded to open the cells with a hollow chisel, commencing at point of mastoid, cutting upward and forward, keeping close to auditory canal. I reached the cells at a depth of one half-inch, and found pus, which continued to flow freely from the wound for three weeks. In dressing the wound I always took the precaution to wash the pus out of wound with a 1 to 40 carbolic solution without disturbing the packing in drill-hole. I then replaced it with fresh powder. No bad effect followed the accident of opening the sinus, and patient made an uninterrupted recovery.

Case 5.—Mrs. W. Autopsy by Dr. S. C. Graves, in presence of Drs. D. M. Greene, G. K. Johnson, and C. H. Johnston.

Body of a woman, fairly well nourished. Height about five feet and six inches. Weight about one hundred and thirty pounds. No external signs of disease except one opening and counter-opening at side of right knee made previous to death for passage of drainage tube.

A. Thoracic Cavity.—1. Lungs: both adherent posterior and superior portions of upper lobes to surface of chest wall. These pleuritic adhesions were not recent, showing evidence of a preceding pleurisy. Lungs, although showing considerable hypostatic congestion, were sound as far as macroscopic appearances were concerned. Portions of the mucose heavily congested. Lungs were removed for microscopic examination.

2. Heart: Normal in every respect.

B. Abdominal Viscera.—1. Stomach, pancreas, liver, spleen, intestines, kidneys, and mesenteric glands, all healthy. Gall bladder contained a half dozen calculi of average size.

C. Pelvic Cavity.—1. Ovaries healthy; uterus corpus healthy; cervix had undergone induration and cystic degene-

ration; cysts six or eight in number, varying in size from a pea to a small marble, contained a thick glairy yellowish fluid, and before being incised were very hard to sense of touch. Bladder: This organ was unopened, no evidence of trouble being present.

D. Cranial Cavity.—1. Dura mater normal.

2. Arachnoid oedematous particularly over vault and somewhat on sides.

3. Pia mater, evidently congested; some fluid in sub-arachnoidian spaces.

4. Encephalon, cerebrum cerebellum, pons and medulla normal.

5. Right lateral sinus as it lay along posterior border of petros portion of temporal bone, filled with a thrombus, showing evidences of suppurative inflammation.

6. Mastoid cells of right side presented evidence of a pre-existing suppurative inflammation; mastoid cells and groove for lateral sinus full of pus, and necrosis very evident; tympanum same as mastoid cells; labyrinth inflamed, no suppuration.

E. Cavity of right knee joint presented evidence of acute suppurative inflammation. Tissues undermined; areas of carious bone both on under surface of patella and on both condyles of femur. Tibial articular surfaces apparently sound.

DISEASES OF THE FRONTAL SINUS.

By D. N. RANKIN, A.M., M.D., Allegheny, Pa., U.S.

[Read before the American Laryngological Association at its Fourteenth Annual Congress.]

By a perusal of the various works on rhinology, you will observe that the diseases of the frontal sinus do not receive the attention they deserve. In my opinion, they are frequently the prime cause of serious, and oftentimes incurable, diseases of the nares; and, *vice-versâ*, very troublesome and painful affections of this locality often result from neglecting slight and curable diseases of the nose. Indeed, the diseases of this accessory sinus of the nose require more prompt treatment in their early stages than those of the antrum highmorianum, owing to the fact of its close proximity to the brain, there being only a thin bony plate between the sinus and brain proper. In the infant at birth there is no trace of the frontal sinuses. They begin to make their appearance between the second and third year, when they are merely enlarged cells in the diploe. They are not fully developed until puberty, when they consist of two cavities often of a different size, the left being commonly the larger, and varying in size in different persons, being larger in men than in women, which sometimes communicate with one another, though not always, but always with the nasal cavities by a separate foramen in each, which opens into the middle meatus of the nose through the anterior ethmoidal cells.

As stated by Sir W. Hamilton, the sinuses are rarely, if ever, wanting in any healthy adult head of either sex. Out of three hundred crania which he examined, he could not find one in which the sinus was completely absent.

The development of these sinuses is usually the result of the receding of the outer and inner tables of the bone from each other. The absence of the bumps, even in middle age, does not necessarily imply the absence of the sinuses, since they may be formed by a retrocession of the inner wall of the skull. In old persons, as a rule, when the sinuses enlarge, it is by encroachment of the inner table on the brain case. Therefore an elderly person may have a large frontal sinus without any external indication of it. On the other hand, a prominent bump does not necessarily imply the existence of a large sinus, or indeed of a small one. The bump may be a mere thickening of the bone. Anatomists inform us that these cavities are lined throughout by mucous membrane, which is continuous with the pituitary membrane lining the nasal cavities, but it differs from the latter in being denser in its texture and paler in colour, as well as being smoother and more highly polished. As there is no trace of these sinuses at birth, the membrane which lines the frontal sinuses, although it is considered to be a continuation of the pituitary membrane, would appear to be developed subsequently to it, as it differs from it, not only in appearance, but in its liability to disease, as diseases of the sinuses are rather more rare than those of the mucous membrane of the nasal cavities. The most important affections of this locality are inflammation, simple and specific, foreign bodies, including insects and worms, polyps, earthy concretions, hydatids, and encephaloid. Simple inflammation of the

frontal sinuses may be caused by an external injury, as a blow on the forehead and gunshot wounds immediately over the sinuses. One case from the latter cause I have had under my care, which, with your permission, I will fully report:—

C. H. P., white, aged thirty-four years, came under my care in the fall of 1864 for the relief of a severe pain in the frontal sinus, with great tenderness and puffiness over the part. The only thing to be seen was a cicatrix from a gun-shot wound. He related the following:—

Was regularly enlisted in the United States Army during the late war. While in the rear of Petersburg, Va., was struck upon the forehead immediately over the frontal sinus by a spent Minié ball, and lay for some hours upon the ground in an insensible condition before reaction supervened; was then carried to the Cavalry Corps Hospital, City Point, Va., where the proper attention was received, and was detained until the wound healed, there being no injury to the bone perceptible, but still continued to suffer from a deep-seated pain—deep in the bone, as he described it. In this condition he deserted from the hospital, as he was expecting at any moment to be sent to the front. After his desertion he came to Pittsburgh, when he came under my care for the relief of this terrible pain in his forehead. I questioned him carefully as to ever having any specific disease; he most positively denied it. In order to satisfy my own mind, I examined him very carefully, and came to the conclusion he was telling me the truth. The usual remedies were given him without any beneficial effect whatever. Acting under the impression that the injury he had received from the gun-shot wound produced inflammation of the membranes lining the frontal sinuses and resulting in the suppuration of that cavity, and there being no hope for an exit through the natural outlet, I deemed it most prudent to open the sinus by trephining, which I did, and was delighted to see more than a tablespoonful of healthy pus exude therefrom, which immediately gave him relief. The cavity was washed out with an antiseptic solution, the crucial flesh wound healed kindly, and he was discharged a happy man. He has written to me several times since, and stated that he has had no return of the trouble.

A few instances are given in some of the older works on surgery of the lodgment of bullets in the frontal sinuses caused by gun-shot wounds, and also where the end of a knife blade or scissors and the sharp end of a metal fence paling, broken off in its passage through the skull, have been found in this locality. Some cases, and they are not a few, are also upon record of inflammation ending in abscess in the frontal sinuses, independent of injury, in which the pus either made its way into the nose, and so escaped, or was retained and gave rise to a train of severe and distressing symptoms.

Tertiary syphilis often attacks these cavities; the symptoms are a sense of weight and fullness, an erysipelatous blush, a heavy aching pain extending along the eyebrows, and the other usual symptoms attending a severe form of coryza.

How often are we called upon to visit a patient who has taken a severe cold and is suffering from a most violent pain in this locality, with chill and high temperature! Any one of us who has seen many cases of influenza, so recently and prominently brought to our notice, could not help but notice the involvement of this locality, the great pain and tenderness in the frontal sinuses, and as soon as we were able, by our remedies, to get a free discharge from the sinuses *via* the nostrils, the patient would immediately get relief, especially from this one violent symptom. But in one instance it was not my good fortune to secure the desired discharge; this case I deem of sufficient interest to report to this association.

On March 30, 1889, J. L., white, aged thirty-two years, hurriedly summoned me to his residence, where I found him suffering most agonising pain, especially over the frontal sinuses. I was informed that two days before he had taken a severe cold, came to his home, had a severe chill, followed by high fever, and excruciating pain in the forehead. I at once surmised the trouble. To relieve his severe pain, a hypodermic injection of morphine was given him, which had the effect of moderating the pain somewhat; but his relief was only temporary, for as soon as the effects of the anodyne had worn off the pain was as excruciating as before the injection was given, if not more so. He was then prescribed phenacetine and salol, followed by a thoroughly antiphlogistic treatment, as salines, aconite, leeching, blistering, etc., but all to no decided good effects. I then commenced poulticing in the hope that whatever pus might be collected in the sinuses would become thinner and pass down through the nostrils. This had no better effect than the preceding treatment. The case becoming worse, with the other symptoms becoming aggravated, some delirium appeared. As every other means had been used to no effect, I decided to open the outer table by trephining,

which I did, giving the man immediate relief; about half an ounce of healthy pus escaped, and, upon examination, I was pleased to find the inner table in a healthy condition, no necrosis having occurred, which I feared greatly, owing to the thinness of the bone.

Professor V. Coszolino gives, in the *Annales des mal. de l'oreille, du larynx*, etc., December, 1891, a description of the instruments and methods which he uses in treating suppurations of these sinuses: "In probing the frontal sinus, the point of a curved probe is passed between the external wall and the anterior end of the middle turbinated upward and forward. The probe will be known to be in the sinus by its direction and by the fact that its end is more than five centimètres from the floor of the nostrils. Great care must be used in treating the ethmoidal sinuses, because of their proximity to the brain. An instrument with a pen-shaped end is used in opening these sinuses. The treatment in all cases consists in giving a free opening and antiseptic washing."

Viallet and Rouger report having met with a case in which a polyp of the frontal sinus was associated with an exostosis of this cavity. Langenbeck and Brume report a case of hydatids in the frontal sinus as follows: "The tumour, during the progress of its development, encroached upon the forehead and roof of the orbit, pushing the eye forward and downward."

Robert Keate, in 1819, published in the tenth volume of the *London Medico-Chirurgical Transactions* the particulars of a case of hydatids of the frontal bone in a girl eighteen years old, but the tumour seems to have been developed in the areolar tissue and not in the sinus, which, however, became accidentally involved during the progress of the disease.

Professor Samuel D. Gross states that encephaloid of the frontal sinus is probably more common than is generally imagined, but in his extensive surgical experience he has seen only one case of it. "The patient was a gentleman upward of sixty years of age, who, twelve months previously, had been seized, without assignable cause, with what he supposed to be an attack of erysipelas of the forehead and face. On recovering from this, he noticed an unusual fullness over the left eyebrow, attended with great hardness and excessive pain. The lids continued to swell and the left nostril by degrees became obstructed and the seat of a thin sanious discharge, more or less profuse, and at times quite fetid. At length several openings formed upon the most prominent part of the tumour, giving vent to thick yellowish pus, and readily admitting of the passage of a probe into the nose. Upon enlarging these openings the sinus was found to be occupied by a soft fungous mass, the over-lying bone being soft and disintegrated. The morbid growth presented all the characteristics, physically and microscopically, of encephaloid. The patient died in a few weeks, completely exhausted."

Fraenkel, in von Ziemssen's *Cyclopædia*, states that "we have trustworthy observations confirming the existence within the frontal sinuses of centipedes, where they may remain for years, the secretions of the cavities furnishing them with sufficient nourishment." It is reliably reported (*Medical Times*, 1876) that larvæ have been found in the sinuses, and maggots that have developed within the nose have managed to make their way to the frontal sinuses. A case is reported where epistaxis, extending over many years, was due to an insect—the *Pentastoma tonioides*—that had settled in these sinuses. One day it was sneezed out, and no further bleeding occurred.

A CASE OF UNUNITED FRACTURE OF THE FEMUR.

By WILLIAM TREACY, M.D., of Helena, Montana.

ON October 30th, 1891, S. S—, a Swede, twenty-six years of age, sustained a fracture of the right femur in the lower third. S— is a man of more than average intelligence, and was a contractor on a railway. From him I obtained the following history:—

Soon after the accident occurred a proper dressing was applied, consisting of a long side splint with coaptation splints and extension. This dressing remained on for five weeks, and when it was removed by the physician in attendance no union had taken place. A plaster dressing was at once applied and allowed to remain for ten weeks. When this was removed there was free motion at the seat of fracture, and there was no evidence of callus or any attempt at union. S— says that the right leg was about four inches shorter than the left at this time, and that he had constant pain above the knee. He concluded to go to Kalispell, and his leg was bandaged firmly to a long side splint, enabling him to make the journey in a waggon without any great suffering. At Kalispell he was given chloro-

form, and an effort made to rub the ends of the bone together, after which a plaster cast was applied. This was removed after remaining on six weeks. When he was examined there was the same degree of motion, with no evidence of union.

He then decided to come to Helena, and arrived at St. John's Hospital on March 12th, 1892. On the next afternoon, with the assistance of Dr. Steele and Dr. Barbour, he was given an anæsthetic and examined. The right leg was five inches and a half shorter than the left. The end of the upper fragment was sharp and directly under the integument; we could not find the lower fragment, and it could not be got into position by extreme extension. We then decided to cut down and ascertain the exact condition. After preparing our patient for an antiseptic operation, an Esmarch bandage was applied in order to render the limb bloodless, and an incision made on the anterior surface of the thigh over the seat of fracture. The upper fragment was easily reached, as it had been forced through the rectus muscle and was only covered by skin and fascia. The lower fragment was not in sight. There was no callus deposited about the upper fragment. The periosteum was dissected back and an inch of bone removed with a narrow-bladed saw. An incision was then made through the rectus muscle, and by extension and flexion we were enabled to bring the end of the lower fragment out through the incision. It had been drawn into the popliteal space by the gastrocnemius muscle. An inch was also removed from the lower fragment and reduction was easily effected. Holes were drilled in the end of each fragment with a Brainerd hand-drill to the medullary canal and a silver wire a tenth of an inch in thickness—sufficiently strong to withstand the action of the muscles of the thigh—was passed through the holes made by the drill, twisted four times, cut short and hammered down on the shaft of the femur to be enclosed by callus. Only one suture was used, and it held the bones in perfect apposition. No ligatures were needed, as there was very little bleeding. After the removal of the Esmarch bandage blood oozed very freely for some minutes, but the oozing soon subsided after irrigating with a very hot bichloride solution for five minutes. The incision was closed with eight sutures, an inch apart. Heavy braided antiseptic silk, well waxed, was used, and the sutures were passed deep through all the tissues. Three strands of coarse catgut were inserted at each end of the incision, for drainage. Catgut was used for the superficial sutures. An ordinary antiseptic dressing was then applied. Heavy binder's board was moulded to the limb, and a long side splint applied without any extension. The temperature was taken morning and evening, and did not rise above 100 deg. Fahr. at any time. There was perfect freedom from pain. The dressing was not disturbed for fifteen days, when the wound was found united throughout without the formation of any pus. Twenty-one days after the operation the long side splint was removed and a plaster bandage inclosing the pelvis applied without disturbing the binder's board coaptation splints.

It is seven weeks since the operation, and the patient has been walking on crutches for ten days; his general condition is greatly improved, he has a good appetite, and is gaining flesh rapidly. His leg will be about two inches short. He has firm union, but has muscular ankylosis at the knee joint, which we may be able to break up hereafter.

MEDICAL LITERATURE.—I.

A BOOK OF THE MONTH.

Manual of Practical Medical Electricity. By DAWSON TURNER, B.A., M.D., F.R.C.P. Ed., M.R.C.P. Lond., Lecturer on Medical Physics and Electro-Therapeutics, Surgeons' Hall, Edinburgh. (London: Baillière, Tindall, and Cox. 1893.)

Specially reviewed for MEDICAL REPRINTS by J. E. BULLOCK, M.D. Brux., M.R.C.S. Eng., &c.]

IN a neatly-bound compact manual of 300 pages, Dr. Turner gives us an admirable and complete exposition of electricity, as applied to the practice of medicine and surgery which is well up to date, and conveyed in a clear and lucid manner, such as will readily attract the attention of practitioners and students for whom the book is intended.

A great recommendation to those who have not mastered the technicalities of physics in their application to electricity is, that the book is very free from "Mathematical and physical definitions and formulæ," only such being introduced as are absolutely essential to explain the text. These, if carefully followed, will enable the practitioner without previous knowledge to understand the elements and appli-

cation of Medical Electricity. We are pleased to note that about half the book (Parts I. and II.) is given up to Electro-Physics and Electro-Physiology, as without a thorough knowledge of these it is useless for the student to attempt to explain the many intricacies of Medical Electricity, the ignorant application of which has led to so much empiricism and imposition. The remainder of the book (Parts III., IV., and V.) treats of Electro-Diagnosis, Electro-Surgery and Electro-Therapeutics. It is profusely illustrated both with explanatory diagrams and figures of the appliances used.

In the introduction it is stated that we cannot exactly answer the question "What is Electricity?" but its connection with heat and light, as of most importance to the medical man, is pointed out, and we see later on in the text how it is utilised for the electric cautery and electric lamp. Under Electro-Physics, the three forms of Electricity (the Static or Frictional, the Galvanic, and the Faradic), the secondary cell and the current from a dynamo, are described and explained in a most clear and simple manner, so that a beginner in electrical reactions can easily follow the *rationale*. Attention is called to the fact of the renewed favour of frictional electricity, especially in France, where in the Salpêtrière Hospital of Paris it is used frequently and successfully for "functional" nervous diseases, such as hysteria and sleeplessness. In Great Britain it has fallen very much into disuse, no doubt owing to the frequent dampness of our climate, when the electricity cannot be generated, and the cumbersome size of the apparatus. The former objection is being overcome by the induction or "influence" machines, of which the Carré and Wimshurst are recommended as probably the most suitable for medical purposes. After describing the action and properties of magnets and the slight resemblance of these to frictional electricity, we pass on to consider galvanic electricity, which, from a therapeutical aspect, is said to be perhaps the most useful form in which we can liberate electricity. Concise description is given of the principles and laws regulating the electric current, and forms of primary cells are described, preference being given to the Leclanché for ordinary galvanic electricity. A few simple rules for charging and managing these cells should be carefully carried out. For instance, a frequent source of failure is the creeping of salts outside the cell, often from the solution of sal ammoniac being too strong. To obviate the escape of salts, either the upper half of the inside of the cell may be smeared with vaseline, or, better still, a cell used in which a recess surrounds the top of the vessel, filled with a material to which the salts will not adhere. Dr. Turner speaks very favourably of the dry Leclanché cell (preferably the Hellesen type); and we ourselves are of opinion that this dry cell, while fulfilling all the ordinary requirements of the general practitioner, will avoid many of the failures which he may encounter with the liquid cell. Its complete portability, and the ease with which an exhausted cell can be replaced, are great advantages.

By a simple yet perfect analogy, the chief considerations respecting medical electricity (electro-motive force, resistance, and current strength) are made clear. Thus, as in the case of two water-cisterns connected together by a pipe, while they are on the same level no flow of water from one to the other will occur, and the flow of water will be greater the greater the difference of level between the two cisterns, so in electricity the "difference of potential" corresponds to difference of level or pressure; and unless there be some difference no current will flow, and the greater the difference the greater is the electro-motive force.

The resistance is aptly compared to that dependent upon the size of the pipe connecting the two cisterns, as the resistance to the flow of water would be greater the longer and smaller the pipe, so is the resistance to the flow of electricity increased by a long thin wire or *vice-versâ*.

Again, in the same way as the force of the current of water depends on the difference of level of the two cisterns and the size of the connecting pipe, so the current strength of electricity depends upon the difference of potential and the size, length, and nature of the connecting wire.

A useful *résumé* of the uses of the various cells, and of their arrangement for different medical purposes, tabulates data which have been laid down and explained.

1. For ordinary treatment by galvanism a large number of cells (10 to 40) are required, which must be coupled "in series" (*i.e.*, carbon of the first cell to zinc of the second cell, and so on); the size does not make much difference to current strength, and dry Leclanché cells (No. 6 Hellesen) are useful.

2. For electrolysis, the only difference is that the cells must be larger.

3. For electric lamps, cells which combine a high electromotive force, with a low internal resistance (bichromate, Hellesen No. 2, or Bunsen) and of large size, must be used, and from 3 to 6 or more in "series." Fifteen Hellesen of the No. 6 size when fresh will light a laryngoscopic lamp for a minute or two at a time.

4. For the galvano-cautery the bichromate or Bunsen in parallel, that is, zinc coupled with zinc and carbon with carbon, or multiple arc, that is, some in series and some in parallel, are required. Ten of the No. 6 Hellesen will heat a cautery for a very short time, but cells of a larger size (No. 2) had better be used.

Thus, if the work for lighting and cautery be limited, the dry Leclanché (Hellesen) cell will meet all requirements, and, where portability has to be considered, its use is acceptable. In the consulting room or hospital, when most weight, etc., is not important, and when high power for lighting or the cautery is required, the bichromate or the Bunsen cell should be used.

The galvanometer, as a measurer of current strength, is next described. The collector, enabling us to add on cells, without breaking the circuit, the current reverser or commutator, a key for reversing the poles, the rheostat, for interposing resistance, rheophores and electrodes, are all explained in their application to medical electricity.

After describing the Faradic current, the chief physical differences between it and the galvanic current are mentioned, e.g., the latter is direct and continuous, the electro-motive force is low and the current strength high. Electrolysis will take place, and the galvanometer forms an accurate index of the current strength, in all which respects it is exactly opposed to the Faradic current.

The requisites for accurate diagnosis are detailed in Part III., and Ziemen's "motor points," at which the muscles are most readily stimulated, are given. The investigation of the reaction of degeneration is very difficult and liable to error, but by following the instructions of Dr. Turner, which are based on the investigations of Erb, and with constant practice, this intricate subject may be worked out.

Under electro-surgery, we turn with special interest to the views of the author upon the electric treatment of stricture of the urethra and fibroid tumours of the uterus. Under the former he writes:—"Linear electrolysis may be used for all kinds of stricture. Owing to the simplicity and harmlessness of the operation, and owing to the greater infrequency of relapses by this method than by others, the author considers that linear electrolysis should be preferred to urethrotomy, and ought to constitute the operation *par excellence* in the treatment of stricture of the urethra." Under the latter he writes: "With regard to Apostoli's three principal claims, we are perhaps justified in saying that it is admitted by nearly all the authorities who have tried his method, that the use of the positive pole, intra-uterine, will diminish hæmorrhage: by many, that the pain and pressure symptoms can be relieved: but by few, that the size of the tumour can be seriously influenced, except, perhaps, by galvano-punctures, which by destroying so much tissue and setting up foci, wherein retrogressive changes, etc., may go on, and which are necessarily followed by cicatrization and contraction, must cause a pro tanto diminution in their size."

A clear exposition of the practical application of electricity for the relief of nervous diseases and for the electric cautery and light conclude this excellent manual.

AMONG the pall-bearers at Lord Tennyson's funeral, it is remarked by the *New York Medical Journal*, was Sir James Paget, who had also officiated in the same capacity at the funerals of Darwin and Browning. To have been invited, says our contemporary, to pay this last honour to the dead in the three most recent burials of great men in Westminster Abbey was not a mere coincidence; it testifies to the high esteem in which the distinguished surgeon is held in the minds of the greatest of his countrymen.

IN America—or, rather, in some of the United States—there is a dog-tax of a dollar a year. In some others there is an annual capitation tax of half that amount, payable by medical men. This leads a medical journal to the following sage and seemingly observations:—"In Michigan they assess a dog a dollar for being a dog. In Tennessee they assess a man fifty cents for being a doctor. It costs half a dollar more to be a dog in Michigan than a doctor in Tennessee! Don't be a dog."

BOOKS.

THE Record Press now publishes a number of books and booklets for medical men and nurses. Among the latter may be mentioned "Points for Probationers," by a member of the Royal British Nurses' Association (E. J. R. Landale), "The Best Thing to Do," (a very compendious and comprehensive ambulance handbook, which, however, some medical men would perhaps consider to go a little beyond the scope of the ordinary "first aid" student, to whom, for instance, instruction in the use of the clinical thermometer perhaps is hardly appropriate), and a neat booklet on "Fever Nursing," by the Matron of the Suffolk General Hospital at Bury St. Edmunds.

"MEDICINAL REMEDIES," by Mr. J. B. Stephenson, Chairman of the Pharmaceutical Society's Scottish Board of Examiners (London: Baillière, Tindall, and Cox), is a handbook of materia medica apparently intended for the general reader. The name of the publishers is a guarantee to the profession that this is no chap-book pandering to the curiosity of the lay mind; it is a simple catalogue of the agents employed in medicine such as (in the opinion of the author) it is desirable that educated and intelligent persons should possess. It is also, no doubt, well that the use of the work should be confined with some strictness to such persons. The Latin names of drugs have been wisely omitted. It is not advisable that even the "educated and intelligent" should read the prescriptions of their doctors too readily.

SHEFFIELD has now an octavo medical journal, published quarterly, under the editorship of Mr. Simeon Snell, F.R.C.S. Edn., with an ample and very able staff. It is a handsomely-printed and very creditable journal, combining a really wonderful amount of general medical information, which will without question give it a circulation and value far from merely local, so that we are glad to note that it is to be issued in London and Edinburgh as well as in its native town. Judging by the second issue, which has just reached us, with its attractive programme of original essays (whereof eight are found in the number under notice), illustrations, abstracts of current opinion in medicine, surgery, therapeutics, obstetrics, and gynaecology, society reports, medical news, and notes of recent discoveries, it seems to us a publication which few medical men aiming to be abreast of current progress should neglect at so small an annual subscription as six-and-sixpence.

DR. SHERMAN BIGG, a recent contributor to these columns, publishes with the Record Press a timely monograph on the practical treatment of cholera, which deals with predisposing causes, and the dangers of defective sanitation, as well as with the medical treatment of the scourge itself. Dr. Bigg has considerable Indian experience, and his observations of cholera, as embodied in this terse and handy little work (which is not too long for the attention of busy general practitioners, while it sacrifices nothing of exhaustiveness), will be deservedly valued by all medical readers. This is a book to be read and kept at hand; it is quite likely that we may have, if not an epidemic, another scare, and to have the best information available compendiously tabulated at hand will even, if happily the knowledge be not required in actual practice, enable the reader to feel at ease when rumours of cholera are rife; and this ease alone will not be dearly purchased at the modest shilling which this book costs.

The *Hospital Gazette*, enlarged and amplified into *The Medical Times and Hospital Gazette*, a title somewhat recalling the old *Medical Times and Gazette* to older memories, has taken a new departure, and gives signs of being a better medical journal than ever. Meantime, from foreign and colonial exchanges, one learns that *The Medical Press and Circular* is winning golden opinions from all sorts of people and in widely diverse places. *The Australian Medical Journal* finds it "becoming increasingly popular in this Colony; it is so bright and honest in its utterances, and is, moreover, not too bulky to be got through." *The Canada Practitioner* says kind things also: "*The Medical Press* is one of the recognised leading medical journals, of a thoroughly cosmopolitan character, and widely read." *The Journal of the American Medical Association*, forgetful that "comparison is odorous," has a word of rebuke for some contemporaries. "*The Medical Press and Circular*," quoth *The Journal*, "is ever welcome in America. It is honest, obnoxious to shams, and has the courage to expose them. One other noteworthy point about this journal is the fact that it is not overloaded with a mass of indifferent material, and does not cumber up one's desk and shelf-room as do the larger and so-called 'great uncut' journals."

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

FEBRUARY 15th, 1893.

We are glad to note the establishment of a home for patients affected with epilepsy and similar disorders. Quite recently there has been opened at Godalming an institution called Lady Meath's Home of Comfort for Epileptics, and a benevolent organisation to be known as the National Society for the Employment of Epileptics has been formed for the purpose of providing for needy epileptics who are able and willing to work, a part of the time at least, but are practically debarred from obtaining situations on account of their infirmities. A series of cottages, it is expected, will be occupied, each of which will accommodate from ten to twenty epileptics. The sexes will be separated, and children and adults will be kept apart. The institution will be conducted on a system similar to what has been so successful at the Bielefeld

Epileptic Colony, and a beginning is soon to be made with a few male patients. Market gardening and spade-and-barrow labour will be among the initial industries, but as the colony extends, other pursuits, and even some of the mechanical arts, will develop. It is hoped that in this way there will be a prospect of self-support, partial at first, growing with the growth of the institution. The colony or home will from the first be under medical supervision, and without sectarian limitations. While it will be primarily for the benefit of the poor, the home will extend its advantages to patients with financial means, who will be received as boarders.

DR. M. SCHÜLLER, of Berlin, has written in the *Archiv für klinische Chirurgie* concerning chronic joint trouble of rheumatic origin. He has had better results from the use of the "Scotch douche" than from the other forms of hydrotherapeutic application in this difficult class of cases.

The Scotch douche consists in the quick alternation of streams of hot and cold water, in a stream of about the size of the little finger, and of a constantly varying pressure, delivered from the same nozzle. This douche is not so well known, says Dr. Schüller, as it should be, and is not found in a number of bathing resorts visited by him. Its good effects are shown by a restoration of the thickened joint capsule, and by a strengthening of the muscular apparatus. The douche should always be used after the warm baths, which are often administered of too high a temperature at the bath establishments.

The Scotch douche has other advantages in the facts that it can be regulated very easily as to temperature, that it can be borne by weak patients, and, above all, that it conveys a distinct mechanical effect, along with its thermal effect, upon the vessels and muscles. The treatment is ordinarily soon followed by a diminution of pain and an increased mobility of the joint. Many cases can be kept for years in an endurable condition by this means which would otherwise be attended by great suffering. In cases that are marked by a relative immobility due to a shrinking and contraction of the capsule, but not due to true ankylosis, the Scotch douche, with an especially delicate massage and passive motion, will assist materially in the increase of mobility. The author has particularly observed this among those of his patients who have been affected in the wrist and ankle joints. The great susceptibility to pain which attends these cases will not permit of the most delicately applied massage, if the latter is tried without the douche; but with the combination these patients feel better, walk or move the limbs with less difficulty, and experience much less pain so long as the treatment is continued.

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NEWS AND NOTES.

CHEAP Dispensaries are justly the object of the *odium medicum* in England; but what will be thought of the German equivalent of this evil as described by a Berlin contemporary, quoting the statutes of the "Krankenvereins der Studirenden der Königl. Technischen Hochschule zu Berlin"? The following is not a joke, as one might possibly be tempted to think, but is copied word for word from the statutes approved by the Rector on the 12th of March, 1892:—

"Any practical doctor or dentist residing in Berlin, Charlottenburg, or the suburbs, can become a member of the Verein, who declares himself willing to give *gratis* to the members of the Verein his advice and help. Every doctor receives upon his becoming a member, the statutes of the Verein, samples of the medical cards, and also certificates for admission. In cases of pressing consultations outside the house, night calls, or operations, the Verein doctor *having* proved his expenses, will receive the same from the committee." To say that there is no reward for the philanthropic efforts of the "Verein doctor" would be cruel:—

"At the death of a Verein doctor a letter of sympathy is to be handed to those he leaves behind, and a wreath will be laid on the grave of the departed by two members of the committee." Judging of the difficulties of making a living by medicine, even where gratuitous physicking is (at least as yet) not in universal vogue, one is tempted to think that the wreath and letter of sympathy so temptingly offered must be pretty often required by the starved medico of Berlin. It is to be regretted that some of the benevolence of the Vereins branch of the profession is not reserved for the poorer members of the craft, or for the inmates of German hospitals, where, if there be anything in the uncontradicted allegations of an American physician publisher not many months ago, in the *New York Medical Record*, the treatment of patients is callous to a degree, many operations which in England no one would dream of performing on a conscious subject being (according to this authority) constantly done without any anesthetic whatever.

THE *Medical Press and Circular* says:—"According to the *Dental Journal*, published in America, the internal administration of antipyrin causes the teeth to become black. This discolouration is more intense when the enamel is defective; nevertheless, experience has shown that the best remedy against it is to thoroughly wash the mouth out with a dilute acid after each dose. Whether this fact has been recognised or not in this country we cannot tell; so far we do not happen to have heard of it." Our esteemed contemporary is a little late in the field. The effects of antipyrin upon the teeth were the subject of a "Therapeutic Note" in *MEDICAL REPRINTS* for October, 1892. We quoted from the *Southern Dental Journal* (U.S.), then latest to hand in London: possibly the information has reached our contemporary *via* these columns. We try not to be last in the field, and for this time at least seem to have succeeded.

THAT very meritorious charity the Princess Louise Home had on the 21st of January the advantage of a benefit performance at St. George's Hall, by the Old Tenisonians' Dramatic Club, a clever amateur company. The programme included a farce, and Mr. W. S. Gilbert's three-act comedy "On Guard," both of which were admirably performed to a large audience. The low comedy part in "On Guard," which is one of the most agreeable of Mr. Gilbert's smaller plays, was well performed by Mr. J. J. Duff, an amateur of considerable

experience and talent, who has for some time been favourably known to frequenters of charity performances. The two ladies' parts were creditably sustained by Miss Dorrell and Miss Kate Arnold, and a word must be said for the excellent rendering of "Baby" Boodle by Mr. F. C. Gibson. The other parts were played with credit by Messrs. Gridley, Arnold, Cartwright, and Vernon Smith, and the whole performance seemed to us to go off with a smartness which would not have done discredit to actors of far greater experience than the ladies and gentlemen who gave their services on behalf of the Princess Louise Home on this occasion. When next they appear on behalf of a medical charity, may we again be bidden to a performance equally pleasant.

ANIMADVERTING on recent discussions on reckless surgery, the *New York Medical Record* breaks into a humorous vein as follows:—"When the window-pane is broken, how demure and quiet all the boys are! No one has done it, and each looks in such innocent wonder at his neighbour that it seems almost cruel to ask questions. The only unpleasant aspect of the affair is the fact of the damage done. Everything else is so refreshingly guiltless that we are almost thankful that the

alleged accident has happened, in order that the inuateness of the good should become so strongly accentuated. So it is," continues our lively contemporary, "with the discussion concerning reckless surgery recently held in one of the leading dailies." How very funny they must manage things in America if medical men discuss surgical ethics in "leading dailies"! "The charge has been made," the *Record* goes on to say (alluding still to matters of lay journalism, it would appear), "with no reason, of course, that surgery is becoming too invasive. If anyone believes that such is possible he has merely to read the conservative interviews and be at once disabused. With the incoming year each and all of us will hail this radical change in opinion with becoming joy."

"WHAT glad news this will be," continues our contemporary, waxing facetious again, "for the little ovary, which can now uninterruptedly carry on its particular home industry instead of becoming domesticated into the pickling-jar of the

progressive gynaecological pathologist! Its commoner and multiplied diseases will vanish, the innocent cyst will no longer be apologetically demonstrated, and operative statistics will dwindle. The peritoneum will no longer be a thoroughfare, and the surprised gut will less seldom twist its bashful coil from the light of day, or join in the unnatural alliances of advanced intestinal anastomosis. The vermiform will gladly retire to private life; the wandering kidney will be more likely to stay at home, and even the gall-stones will elbow their faceted sizes through the dark tunnel of the common duct in the good old-fashioned style, only to be lost in the harmless embarrassment of a delayed stool. Let us hope, then, that the surgical millennium is coming, that the knife shall be turned into a spoon, that the pill shall once more have its right of way, that the ovary shall hereafter peacefully wrap the drapery of the broad ligament about her and lie down to pleasant dreams of families yet to be."

THE stains used in microscopic work (says the *Canada Lancet*) are sure to leave their mark on the hands of the operator, and those who use pyoktanin, in ordinary practice, seldom escape the evidence of their manipulations. A little alcohol, or hydrochloric acid, will generally remove the greater part of these dyes, but to do it completely, some bleaching agent is required. Unna has lately recommended a method



WILLIAM M. POLK, M.D., LL.D.

which is convenient and unobjectionable. The hands are first washed in a solution containing a little—say five per cent.—of common salt, and then in hydrogen peroxide solution, of about the same strength, being finally wiped with a cloth moistened with alcohol.

* * *

THE following extraordinary news (says a Berlin correspondent) comes from San-Luis Potosi, in Mexico, where an epidemic of typhus lately raged. A priest, one Ortis, introduced as an antidote against this destroying disease a new cure, and which he claimed to have learned in Indian territory, where he was for some time engaged as missionary. The cure consists of frog soup. The unfortunate frogs are first broken up in an iron mortar, and then, by means of water, converted into a thick broth, which the patient, almost equally unhappy, must swallow. Even six hours after the first dose an improvement in the condition of the sick man is supposed to take place, followed after a few days by a complete cure (?). Unfortunately, adds our informant, with humour, the reverend Ortis finds only a few patients who are willing to undergo his cure, which, perhaps, is not on the whole surprising.

* * *

DR. ALI KROGINS, Physician to the Helsingborg Surgical Hospital, reports an epidemic of sham temperature among patients in his charge. Three men and one woman either simulated a non-existent fever, or exaggerated their actual high temperature, by rubbing the bulbs of the thermometers in the folds of their dress, or by tapping with the finger on the upper end of the instrument, so as to jerk up the register. The fictitious temperatures were carefully adjusted, so as to simulate enteric fever, the evening temperature being made higher than the morning. By using two thermometers simultaneously, one in the rectum and one in the axilla, and by careful watching, the fraud was discovered; and the "weaker vessel" confessed that she learned the trick from a woman in another town. No doubt the means adopted for the detection of the fraud were admirably chosen; but how on earth does Dr. Krogins contrive to take temperature in such a way as to make such an imposition possible? The report is quoted from an American medical contemporary. Perhaps it is, after all, but a bad joke; for the dexterity imputed to the patients is almost as miraculous as their alleged intimate acquaintance with pathological thermometry. Moreover, one would like to know what benefit the said patients supposed themselves to derive from the fraud.

* * *

THE *Union Médicale* for December 27, 1892, gives a short account, from the *Revue Scientifique*, of the *Pleurotus lux*, a fungus that takes its specific name from its property of glowing in the dark, even for twenty-four hours after it has been plucked. It has lately been carried to Europe from Tahiti, where the women use it as an adornment in bouquets of flowers. A phosphorescent fungus, often found in the backwoods of the Western States of America, is possibly identical with that above described.

* * *

An interesting paper dealing with the association of prostatitis and bicycle-riding, was read at a recent meeting of the Louisville Medico-Chirurgical Society, by Dr. J. W. Irvin. The author said that within the last eighteen months five cases of prostatitis had come under his notice, the cause of which could be distinctly traced to the pressure by the saddle of the bicycle on the prostate gland. Four of the patients were past middle age, and the other was a boy. The symptoms commenced after riding the machine for a few hours. The act of micturition was accompanied with a feeling as though the vesical end of the urethra was raw. Inordinate and persistent priapism followed, coming on at short intervals, and lasting three or four days. Some dull pain was felt in the testes. There was no discharge from the urethra at first, but after two or three days a little moisture would ooze out of the meatus urinarius. The discharge was thin and colourless.

* * *

THE Faculty of the Columbian University in Washington has withdrawn the privileges previously offered to women in the medical department. The reason assigned is that the presence of women as students kept men away, and they had no desire to become a female seminary. They also considered that the teaching of men and women together was demoralising to both. The last assumption seems rather gratuitously offensive, and if (as stated) the presence of ladies keeps away male aspirants, how very differently constituted the American medical student must be from his home congener!

So old Dr. Warburg, of Fever Tincture fame, is dead at last! He, his history, his tincture, and his secret, all were alike curious. The formula of the famous tincture reads like a mediæval receipt, or what medical slang in America calls a "shot gun" prescription—a mixture which contains so many ingredients that, if one doesn't cure, it is hoped that another will. No rational explanation of the action of the tincture has, so far as the present writer is aware, ever been published. Yet, whatever the *rationale*, the tincture undoubtedly does what no other drug or combination of drugs (and a "combination" it certainly is) ever has done, or perhaps ever will do. The generally accepted theory, if theory it can be called, is that in some mysterious way the potency of the active ingredients is increased or reinforced by their combination with the various other substances. Certain it is, that in some cases of tropical and intermittent fever, where quinine fails utterly, even in the heroic doses mentioned by Surgeon Parke in his African book, and where the patient seems to be slipping out of hands, Warburg's Tincture, exhibited in the nick of time, stops the rigours, and sends the sufferer off into a painless sleep, bathed in a gradual and oddly aromatic perspiration, which carries off the fever as if by magic, and seems to snatch the patient from the very jaws of death. Knowing as little as we do of the precise action of the drug, one sees the importance of adhering to the exact formula published by the inventor—"the discoverer," as he delighted to be styl'd. Very tragic failures are over and over again traced to the use of tinctures sold in the open market as Warburg's, but found too late to vary from the true recipe. The fact is that, though since the publication of the formula the tincture has been nominally made by all and sundry, there are one or two ingredients not in the reach of the ordinary druggist, and a general carelessness has been shown in making up tinctures only roughly resembling the original preparation. It is perhaps permissible to point out that Dr. Warburg's accredited agent supplies tincture exactly corresponding with the formula at a very cheap rate to medical men, and that only by using this tincture can it be in any way relied upon.

* * *

THE story of Warburg's attempt to monopolise the "discovery" is too well known to need repetition here. No doubt he offended gravely against the ethical canon herein; but he made submission and amends, and, after all, he gave us a remedy which the profession, especially in miasmatic and tropical countries, could ill spare. But for his unethical action in the first instance, it is probable that the formula would never have been used to anything like the extent it now is, for it would tax the most capacious memory, and would then be exceedingly difficult to get dispensed in its integrity. A good many valuable lives had been saved by it, which would have been lost had it been merely a formula, and not a commercial drug readily obtained on occasion.

AMERICAN OPINION.

REMEDIAL PROPERTIES OF APPLES.

[From *The North American Practitioner*.]

CHEMICALLY the apple is composed of vegetable fibre, albumen, sugar, gum chlorophyll, malic acid, gallic acid, lime, and much water. Furthermore the German analysts say that the apple contains a larger percentage of phosphorus than any other fruit or vegetable. The phosphorus is admirably adapted for renewing the essential nervous matter of the brain and spinal cord. It is, perhaps, for the same reason, rudely understood, that old Scandinavian traditions represent the apple as the food of the gods, who, when they felt themselves to be growing feeble and infirm, resorted to this fruit, renewing their powers of mind and body. Also, the acids of the apple are of singular use for men of sedentary habits, whose livers are sluggish in action, those acids serving to eliminate from the body noxious matters which, if retained, would make the brain heavy and dull, or bring about jaundice or skin eruptions and other allied troubles. Some such an experience must have led to our custom of taking apple-sauce with roast pork, rich goose, and like dishes. The malic acid of ripe apples, either raw or cooked, will neutralise any excess of chalky matter engendered by eating too much meat. It is also the fact that such fruits as the apple, the pear, and the plum, when taken ripe and without sugar, diminish acidity in the stomach, rather than provoke it. Their vegetable juices are converted into alkaline carbonate, which tend to counteract acidity.

TAPE-WORMS.

[From the Philadelphia Medical and Surgical Reporter.]

A REVIEW of a certain French article on the tape-worms of man, which is now going the rounds of the medical journals, deserves a word of correction. The review states that a French scientist, M. Colin, has recently discovered that the tape-worm which man obtains from beef is identical with the tape-worm obtained from pork, and that it is impossible to determine whether a person has become infected from pork or from beef, even by a careful study of the parasite passed by the patient.

These statements, however, are totally false, and it seems almost impossible that medical journals should give any credence to such claims, when zoologists have worked the matter out so carefully and have given us so many characteristics by which we can distinguish between the two forms.

The two species in question are known to medical zoologists under the name of *Tenia saginata* ("the beef-measle tape-worm") and *Tenia solium* ("the pork-measle tape-worm").

The beef-measle tape-worm is contracted by eating the larva (so-called *Cysticercus bovis*) which is found in the muscles of beef, especially in the muscles of the jaws and tongue. The head of this parasite is provided with four suckers, but bears no hooks. If a mature segment of the worm is compressed between two glass slides and held up to the light, the uterus will be distinguished in the form of a straight stem running longitudinally and giving off numerous (15 to 30) branches on each side.

The pork-measle tape-worm on the other hand possesses two circular rows of small hooks on the crown of the head, as well as four suckers, similar to those found in the beef-measle worm. Upon compressing a segment between two glass slides it will be seen that the uterus possesses but 8 to 12 branches on each side.

With the aid of a microscope it is also possible to notice distinct differences in the size and shape of the eggs produced by the two worms.

The statement that M. Colin claims that both hogs and cattle are infested by the same species of larva is easily explained.

Under normal circumstances, the larvæ found in the muscles of hogs possess a double row of hooks on the head. Occasionally, however, the hooks fall off and a larva is obtained which resembles very closely the larvæ found in beef, which, as stated above, are never armed with hooks. M. Colin evidently had one or more of these degenerated larvæ before him when he made his statement that the two forms were identical.

It may possibly occur to some physicians that it is immaterial whether a man has the beef-worm or the pork-worm; but such is not the case, since the pork-worm is much more dangerous than the beef-worm. If a patient harbours the armed form he is not only subjected to the inconveniences arising from the presence of a parasite in his digestive tract, but he is constantly in danger of re-infecting himself with the eggs of the worm. The eggs of the parasites are present in the feces, and may, by various means, be transferred to his food and thus to his mouth. Upon arriving in his stomach the egg-shell is destroyed and a six-hooked embryo is set free. This embryo then bores its way through the intestinal wall and wanders to some muscle, to the inside of the eye or even to the brain, and develops into the larval form (*Cysticercus cellulose*) the same as it would do in the muscles of hogs.

The embryo of the beef-measle worm, on the other hand, cannot develop into a *Cysticercus* in the human muscles, and a man may swallow any number of the eggs with perfect impunity.

From this it will be seen that the physician should know whether his patient harbours the beef-worm or the pork-worm. If the latter is present, it should be removed immediately in order to prevent infection with the larvæ; further, if this worm is passed, the physician should be very careful in handling it, as he may infect himself with the ova. The other worm, however, can be handled without fear of infection.

The infection of human muscles by *Cysticercus cellulose* (pork-measles) is not at all uncommon in Europe, but, fortunately, it is very rare in this country, since the adult parasite itself is of rare occurrence in America.

The tape worm which is most frequently found in America is *Tenia saginata*.

The two species are not the only tape-worms found in man. *Bothriocephalus latus* (the broad Russian tape-worm) is obtained from fish. This parasite is very frequent in Russia, but has been recorded only four or five times in this country. *Bothriocephalus cordatus* and *Bothriocephalus liguloides* are two other species which are supposed to come from eating

larvæ in the muscles of fish. *Hymenolepis nana* is an extremely small tape-worm which is quite frequent in Italy, but has been recorded but twice in the United States. *Hymenolepis diminuta* (*Tenia flavo-punctata*) is a small tape-worm of rats, which is occasionally found in men. *Dypilidium caninum* (*Tenia cucumerina*) is a common tape-worm of dogs, which is now and then found in children. The larval stage of this worm lives in the fleas of dogs, and children become infected with the parasite by swallowing, consciously or unconsciously, fleas containing the larvæ.

The presence of a tape-worm can be definitely diagnosed by finding the loose segments in the stools, but if any doubts exist as to the presence of the parasites, any expert microscopist can settle the question by a microscopical examination of the feces.

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and those accepted will be paid for at the rate of One Guinea a column, when original.—EDITOR MEDICAL REPRINTS.]

SOME USES OF SALOL.—In some cases of very extreme flatulence from intestinal dyspepsia, where many of the usual recognised remedies have been tried and have failed, I have had surprising results from the administration of five grains of salol every two or three hours. The relief is almost immediate.

In cases of infantile diarrhoea, where there is marked fermentation going on in the intestines, I have found salol in doses of gr. ss to gr. i every two hours of very great service. This, of course, is little more than palliative. To complete the treatment, and to help the enfeebled infantile digestion, I find nothing so serviceable as Lactopeptine in doses of grs. ii or grs. iii with each meal. The Lactopeptine is often sufficient of itself to cure the diarrhoea.

As a lubricant in gynecological and midwifery cases, I recommend the use of an ointment of salol and white vaseline grs. xx ad ʒi well rubbed up. The anti-epileptic and persistent fragrant properties of the salol make it especially suitable for a lubricant in these cases.

I have also had very good results from the use of salol in doses of grs. v to grs. x, every four hours, in cases of cystitis—the rapid improvement in the smell of the urine being very marked, as also the comfort of the patient.

A. H. WILLIAMS, M.D. Edin.

HOW TO ADMINISTER THE ETHEREAL EXTRACT OF MALE FERN.—Dr. Crequy prescribes in *Lo Sperimentale* the ethereal extract of male fern as follows:—

R	Ethereal extract male fern	...	...	...	gms 5
	Calomel	...	...	...	dgms. 8

Sufficient for fourteen capsules. Two capsules every ten minutes.

This prescription is based upon the fact that the active and toxic principle of the male fern is soluble in fatty oils. Hence castor oil, the common purgative after male fern, should be avoided in the expulsion of tenia by this drug.

BISMUTH SUBNITRATE IN BURNS—NEW MODE OF EMPLOYMENT.—In burns Dr. K. von Bardeleben, of the Friedrichstein Hospital, Berlin, employs tarlatan bandages impregnated with a mixture of equal parts of bismuth subnitrate and powdered starch. These bandages are applied directly to the affected parts, which are previously washed and disinfected with a three per cent. solution of carbolic acid, or with a three-tenths per cent. solution of salicylic acid. The first dressing of this kind is left in place at least eight days, and, if necessary, for two and even four weeks.

As can readily be seen, this dressing is not applicable to burns of the face, which we can but simply powder with bismuth—a procedure which the author regards as defective and slovenly, and one in which a considerable quantity of the medicament is wasted.

In burns occasioned by chemicals, it is deemed necessary, before employing the bismuth dressing, to neutralise the caustic which has penetrated the tissues, by means of washing with lime water if an acid was the escharotic, or with vinegar if the burn was produced by an alkali.

CORYZA, CEPHALALGIA, AND ASTHMA.—Dr. Coupard (*Münchener med. Wochenschrift*) recommends in asthma, coryza, and cephalalgia the following powder:

R	Cocaine hydrochlorate	...	...	...	grs. ij.
	Menthol	...	...	...	grs. iv.
	Boric acid	...	...	...	grs. xxx.
	Finely powdered roasted coffee (!)	...	...	...	grs. viij.

CORYZA.—

R Naphthalin in an impalpable powder	... 3 vj
Powdered boric acid	... 3 vj
Powdered camphor	... gr. xv
Extract of violets	... gr. xv
Essence of roses	... gtt. xx

Sig.—Mix and use as a snuff in coryza.

—*L'Union Médicale.*

CORRESPONDENCE.

To the Editor of MEDICAL REPRINTS.

DEAR SIR,—You were kind enough to forward me, a short time since, a sample bottle of your Lactopeptine, for which I am much obliged. I am glad to be able to inform you that it has proved of signal service in an obstinate case of chronic dyspepsia at present under my care, and I shall certainly recommend it in future in similar cases.—Yours faithfully,

J. M. WALKER, M.B.

4, Belgrave Road, Edgbaston, Birmingham, Jan. 28th, 1893.

THE LATE DR. WARBURG.

A BOUND book with silver-print photograph, larger than cabinet size, on the late Dr. Warburg's treatment of fever, with letters from a number of distinguished medical men, travellers, and others, and some very interesting fac-similes of Government communications and other documents, may be had, post free, for three stamps, from Dr. Warburg's accredited licensee (who prepares the tincture in strict conformity with the formula, and sells it in bulk to medical men at the rate of 18s. a pound). The supply of this book (which will not be reprinted) is getting small, and early application is therefore advised. Applications should be made to John M. Richards, 46, Holborn Viaduct, London.

BACK NUMBERS OF MEDICAL REPRINTS.

The following issues are out of print:

No. 1 (February, 1890).	No. 14 (March, 1891).
No. 7 (July, 1890).	No. 17 (June, 1891).
No. 10 (November, 1890).	No. 19 (August, 1891).
No. 13 (February, 1891).	No. 22 (November, 1891).

Any other back number will be sent post free to any medical man on receipt of three penny stamps.

No. 30 (July, 1892) contains:—

Fibrous Mammary Tumours. By Chas. N. Dowd, M.D. (With Five Illustrations).—Removal of a Glass Rod from the Peritoneal Cavity of a Woman. By W. Gill Wylie, M.D., &c.—Relation of Rheumatism to Chorea and other Neuroses. By E. Blake, M.D., &c.—A Modification of Wyeth's Method of Bloodless Amputation at the Hip Joint. By Prof. Stuart Le Roy McCurdy, M.D. (With Two Illustrations).—News and Notes.—“Women in Medicine” (Letter) “Fair Play.” (M.D. Edin.)—Portrait: The late Sir Oscar Clayton.

No. 31 (August, 1892) contains:—

A Study of Typhus Fever. By J. W. Brannan, M.D., and T. M. Cheesman, M.D., &c. (With Two Illustrations).—An Extraordinary Effort of Nature to Relieve an Intussusception. By E. M. Culver, M.D. (With an Illustration).—Case of Syringomyelia. By W. Vought, M.D., &c. (With Two Illustrations).—A Contribution to the Study of Cerebral Tumours. By P. C. Barker, M.D. (With an Illustration).—News and Notes.—American Opinion.—Therapeutic Notes.—Portraits: Sir J. Fayrer, M.D., &c., and Mr. Jabez Hogg, M.R.C.S.

No. 32 (September, 1892) contains:—

The Opium-eaters of Lincolnshire. (Original Article.) By G. Rayleigh Vicars, M.A. Cantab., M.B. St. Andrews, &c.—Two Cases of Myxœdema, with one Autopsy. By Prof. H. C. Gordinier, M.D. (With Eight Illustrations).—Remarks on Dyspepsia. (Original Article.) By E. A. Piggott, L.R.C.P. & S. Edin., &c.—Fracture of Lower Jaw. By A. O. Stimpson, M.D. (With Three Illustrations).—Continental Practice: Notes on Soaps. By Dr. H. Paschke of Vienna.—Sir Joseph Fayrer and Mr. Jabez Hogg: A Communication.—News and Notes.—American Opinion: Surgery under Hypnosis. Childbirth with Erysipelas.—Therapeutic Notes.—Correspondence. Portrait: Sir Richard Quain, Bart., M.D., F.R.S.

No. 33 (October, 1892) contains:—

Is Indigestion Curable? A Symposium. By Prof. Arthur Gamgee, F.R.S. F.R.C.P. Edin., &c.; F. W. Clark, L.R.C.P. Lond., M.R.C.S. Eng., &c.; Carey Coombs, M.D. Lond., &c.; James Kelly, L.R.C.P. Edin., L.R.C.S. Edin., L.F.P.S. Glasgow, &c.; J. E. Bullock, M.D. Brussels, &c.; W. L. Ross, M.D. Edin., &c.; and A. Ambrose, M.D. Dublin, B.A., LL.B., &c.—Lateral Deformity of the Spine in Pott's Disease. By John Ridlon, A.M., M.D., &c. (With Four Illustrations).—Gastric Disorders and Nervous Symptoms. By George Miller, M.B.

Glasgow, &c. (Original Article).—An experimental Contribution, Looking to an Improved Technique in Enterorrhaphy. By M. E. Connell, M.D., &c. (With Eight Illustrations).—News and Notes.—Therapeutic Notes, &c.—The Cholera in Russia. (With Four Illustrations.) From Photographs taken at Nijni Novogorod during the Epidemic.

No. 34 (November, 1892) contains:—

Habitual Constipation. By G. Sherman Bigg, F.R.C.S. Edin., &c.; Peroxide of Hydrogen in Ear Diseases. By W. B. Johnson, M.D., &c.; An Efficient Method of Controlling Hemorrhage after Suprapubic Prostatectomy. By E. L. Keyes, M.D. (With Two Illustrations); Peculiar Case of Chronic Ascending Poliomyelitis Anterior. By C. E. Lockwood, M.D., &c. (With an Illustration); Case of Keloid of the Male Urethra. By George Minges, M.D. (With an Illustration); An Extreme Case of Suspended Animation from Chloroform. By A. E. Prince, M.D., Ph.D., &c.; Continental Practice.—News and Notes.—Therapeutic Notes.—Portrait: The late Sir George Macleod.—View: The Victoria Hospital, Hull.

No. 35 (December, 1892) contains:—

Cocaine in Acute Inflammations of the Ear. By J. Wolfenstein, M.D., &c.; Symphysectomy, with Report of an Operation. By B. C. Hirst, M.D., &c.; Method of Repairing Broken Nose. By W. H. Daly, M.D., &c. (With Two Illustrations); Clinical Lecture: Fistula in Ano. By Lewis H. Adler, jun., M.D., &c.; American Opinion.—Quarantine. By Stephen Smith, M.D., &c.; News and Notes.—Cough Mixtures.—Alcoholism and its Treatment. A Symposium.—Correspondence.—Therapeutic Notes.—Portrait: Sir B. W. Foster.—View: Victoria Hospital, Folkestone (Queen's Jubilee Memorial).

No. 36 (January, 1893) contains:—

Therapeutic Value of Lactopeptine. By Edward A. Piggott, L.R.C.P. and S. Edin., &c.; Case of Anteversion. By H. Hobart Dorman, M.D. Dub., &c.; Excision of the Ossicula in Chronic Aural Catarrh; with instance of a failure. By H. V. Wurdemann, M.D. Diagnosis of Spinal Cord Lesions. By F. Peterson, M.D. (With Five illustrations).—Case of Late Hereditary Syphilis, with Nasopharyngeal Lesions. By J. F. Klinedinst, M.D. (With an illustration).—American Opinion.—News and Notes.—Continental Practice.—Therapeutic Notes.—Portrait: Sir Richard Owen.—Views: Sheen Lodge.—The Northern Hospital, Liverpool.—The New Psychiatriche Klinik, St. Petersburg.—Index, Frontispiece, and Title-page to Volume III.

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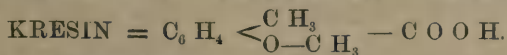
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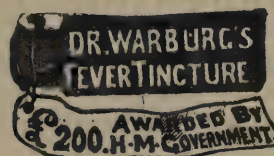
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Treatment of Syphilis
by Succus Alterans (McDade), with
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Profession only.

Most Medical Men

have noted the extremely uncertain action of even the best Pepsins used as a remedy in Dyspepsia. Most medical men are familiar with the objection of patients to even the most palatable preparations of Pepsin. Both these difficulties are abolished where Lactopeptine, a standard remedy of published formula, is used instead of Pepsin. It is perfectly palatable as now prepared. It cures wherever Pepsin cures, only better: it cures in numerous cases where Pepsin fails.

Lactopeptine is not a single digestive; it is a combination of *all* the digestive agents in the human organism—Pepsin, Pancreatin, and Ptyalin—and will digest every form of food used by man. Its Pepsin is the most active in the world, and is combined with the necessary acids; its Pancreatine is of the same standard, and acts in the post-duodenal alkaline juices, thus curing intestinal dyspepsia as well as ordinary gastric incapacity.

Lactopeptine, therefore, is an ideal remedy, and may be relied upon wherever imperfect digestion is a factor in disease. A 4s. 6d bottle sent free of charge to any medical man not acquainted with this remedy on request, with pamphlet containing opinions of "**British Medical Journal**," "**Medical Press and Circular**," "**Braithwaite's Retrospect**," and other publications, and those of a large number of medical practitioners.

JOHN M. RICHARDS, 46, Holborn Viaduct, London. Telegrams: "ADRIATIC, London."

Printed for the Proprietor by ROBSON & SONS, Limited, Fetter Lane, London, E.C., and published by him at 46, Holborn Viaduct, in the City of London.

MEDICAL REPRINTS

Home, Foreign, and Colonial: with Original Essays.

VOL. IV.]

LONDON: MARCH 15TH, 1893.

[No. 38.]

THE TREATMENT OF CONSTIPATION.

By JAMES D. STAPLE, M.R.C.S.England, L.S.A.London, late Visiting Surgeon and Senior House Surgeon Stockport Infirmary; Junior House Surgeon South Devon and East Cornwall Hospital, Plymouth; Assistant House Surgeon Norfolk and Norwich Hospital, Norwich; and Resident Assistant St. Luke's Hospital for Lunatics, London.

[An Original Essay specially written for MEDICAL REPRINTS.]

I HAVE already sent some short articles to the *Medical Times and Hospital Gazette*, *MEDICAL REPRINTS*, and the *Lancet* on the value of glycones in constipation. As I have been using them extensively since then, I think that perhaps an article enumerating some of the cases, may be of interest.

"Glycones" are suppositories of glycerine and contain ninety-three per cent. of that drug; each has a waterproof covering. By slightly pressing the suppository between the fingers, it slips out quite easily; leaving the covering between the fingers. They are made in two sizes, for children and adults. They can be inserted without any trouble or pain, and patients can readily insert them for themselves.

Glycerine lubricates and softens the fæces and also gently stimulates the bowel, when given in the form of a glycone.

The following are the principal advantages of giving Glycerine by this method:—

1. Perfect immunity from pain after their introduction.
2. Ease of administration (patients can readily use them themselves).
3. Rapidity and certainty of their action. (This generally occurs in a few minutes; it has been a rare occurrence for me to have to repeat the suppository).
4. Entire absence of any griping following their use.

Glycones are useful in the constipation of children, and are certainly a more convenient way of giving an aperient, than the soap enema, so frequently used. In midwifery and gynecological practice they are most useful, as a "loaded" rectum often causes delay in labour, and it is always advisable to open the bowels before putting on the forceps, turning, reducing a retroverted uterus, etc., and by these little articles we can easily and rapidly have the bowels emptied, without the fuss of the old-fashioned enema. I remember a case, that of a patient with far-advanced cancer of the uterus, the nurse was in the habit of giving her an enema to get an action of the bowels; the patient complained to me of the great pain attending its introduction, I suggested the glycerine suppositories, which proved very satisfactory, and quite painless to the patient.

Glycones are particularly useful in cases where an aperient by the mouth is not advisable; for example, in any inflammatory affections of the digestive system, as enteritis, typhlitis, enteric fever, and peritonitis. When the bowels have to be opened in any of these diseases, nothing can be so useful as one of these little suppositories, owing to the entire absence of any irritation following their use. I remember a bad case of lead poisoning to which I was called; the man was suffering from the usual symptoms that workers in lead frequently have, he had not had his bowels opened for some days. I ordered him the usual mixture of sulphate of magnesia, potass iodide, etc., by the mouth, and gave him a glycerine suppository at once, which soon had the effect of relieving his constipation. In old people, especially females, who suffer from a form of chronic obstruction of the lower bowel, caused by hardened masses of fæces, glycones are most useful as the glycerine lubricates the masses, and they are evacuated without pain.

Lunatics often suffer from a very obstinate form of constipation, and when holding an appointment in a large lunatic hospital, I recollect the trouble we occasionally had with this class of cases, how we gave enemata, and then often eventually had to remove the faecal matter with a scoop, which is certainly, as Erichsen says in his work on Surgery, one of the most unpleasant duties that the surgeon has to perform. I

held that appointment before the introduction of glycones, but I am perfectly certain that had I been able to have had some of those handy little articles, it would have saved me a vast amount of unpleasantness and trouble, as I have since given these glycerine suppositories in very obstinate forms of constipation; for example, the constipation met with in patients suffering from hemiplegia and other brain affections, and have never known them fail, although sometimes it has required a second suppository to bring about the desired effect. During the past few weeks there has been some correspondence in the *British Medical Journal* on the treatment of constipation in children; some writers have recommended glycerine injection, senna tea, black draught, enema of soap and water, cascada (a wine containing the active principles of cascara sagrada); I would venture to suggest that glycerine would be found the most suitable remedy, and the best mode of administering the drug is by means of a glycone.

In conclusion I may add, that I have now used these little suppositories for some years, and use them more each year. They certainly are a most valuable addition to our stock of drugs, and only require to be better known, and then they will be utilised far more than they are at present.

HOW AMPUTATION OF THE BREAST FOR CARCINOMA SHOULD BE PERFORMED.

By ROBERT F. WEIR, M.D., Professor of Surgery, College of Physicians and Surgeons, New York.

[Read at the Meeting of the New York County Medical Society, held November 28th, 1892.]

THE subject upon which I wish to speak to-night is an extremely trite one, and I can add but little of novelty to it. Nevertheless I think the experience of every hospital surgeon will bear me out in this, that while the removal of the female breast for carcinoma is an operation that is frequently undertaken by the ordinary practitioner, in a large number of instances it is done in an imperfect manner. Either the operator will content himself with the removal of the tumour, together with a moderate portion of the adjacent mamma, or he may more thoroughly take away the entire breast with the tumour. He seldom, however, opens and examines the axilla, and still more rarely does he enucleate this space of its fat-contents and glands, which are estimated to be invaded in ninety-seven per cent. of mammary carcinoma. This latter omission is especially true in those instances where, prior to the operation, no glandular enlargement can be detected, even after repeated and careful examinations. That this inference is erroneous has been demonstrated many times by surgeons. Experience has decisively shown that such an examination is not a reliable one; that even the opening up of the inferior portion of the axilla, after the breast has been removed, and the introduction of the finger under the skin into this space is not sufficient in many instances for the detection of involved glands. The discovery of enlarged glands in the axillary fat has been so frequently found by me in cases where no evidence of the existence of such could be felt prior to the operation that I speak with positiveness on this subject. In fact, according to the carefully observed cases of Schmidt, at Küster's clinic in Berlin, twenty-six per cent. of the cases not presenting, previous to operation, axillary involvement to the usual palpation revealed enlarged glands at the time of operation.

Passing on further, and as briefly as possible, as my time is limited, the following may be stated almost as axioms:—

First. That every mamma in which a cancerous nodule exists is already very extensively diseased—perhaps *in toto*.

Second. That secondary infections take place either through the axillary glands and lymphatics, or through the adjacent skin; or, lastly, through the retro-mammary fat and fascial tissues alone, or in addition through the lymph-vessels of the pectoral fascia and of the pectoralis major muscle itself.

From these facts it is equally evident that the whole breast

must be removed, and that the section through the skin must be made wide of the growth, irrespective of the formation of a line of subsequent union; also that the axillary contents should be thoroughly cleaned out; and finally, and perhaps most important, if the disease extends to the depths of the gland, that the pectoral fascia, and generally a portion of the pectoralis major muscle itself must also be removed.

The usual incision, starting on the arm at about the insertion of the pectoralis major muscle with the humerus, is carried along the lower edge of this muscle rather than in the axilla itself, and encircles the breast below and above the tumour. Dissection through the subcutaneous fat will now, by turning back the separated skin, easily expose the mamma *en masse*. These incisions, I repeat, should always be planned on the basis of going wide of the affected part. Unluckily we have no way of determining how far away this section should be, or how much of the skin tissue of the breast should be sacrificed. Two procedures have been suggested, one of which has been in use for some time, to aid the surgeon in this endeavour. The first is, by the aid of a competent assistant, to make at the time of the operation a frozen microscopic section of the diseased skin tissue nearest the carcinoma, in order that the operating surgeon might be informed before the close of his work whether or not he may have taken away a sufficient amount of the skin and other tissue. This has been resorted to for some time past by myself, as well as by other surgeons, and the delay in the operation has been so trifling that its advantages more than counterbalanced this defect.

The second method, which I can only allude to, for my own experience has been confined to but a few cases, is that suggested by Stiles, of Edinburgh, and it is this. To immerse the amputated breast, previously washed in water in order to remove the blood, in a five per cent. watery solution of nitric acid, and to leave it there until the operation of cleaning out the axilla has been accomplished, say ten minutes. It is then washed again in water. By this time such alterations will have taken place from the action of the nitric acid on the normal tissues as will render them semi-translucent, while the carcinomatous patches will remain opaque. This ready method has been endorsed by Professor Chiene and by Messrs. Woodhead and Brooks.¹ Moreover, since we have learned that the large gaps, particularly such as are frequently left after the free removal of the mamma, and which are often so extensive that the edges of the skin cannot be joined again together, can be satisfactorily and promptly closed by Thiersch's method of skin-grafting from the thigh, there need be no hesitation on the part of the surgeon to sacrifice more of the skin than has theretofore been done. This is an important point, because it is admitted by all that the recurrences are most common, viz., seventy per cent., in the skin and in the tissues near the site of the original infection. It is for the further avoidance of this recurrence, for in the axilla recurrence is rare—less than two per cent.—that, in addition to the liberal removal of skin, Heidenhain, of Berlin, has proposed that always in the deep involvement of the mamma, or when the retromammary fat or tissue is invaded by the neoplasm, not only these tissues should be widely removed, but that a goodly portion of the pectoralis major muscle itself in the mammary region—in his own words, “a continuous layer of the muscle substance”—should be cut away. This I can testify can be done to an extensive degree, either without after-impairment in most cases, or, in rare instances, with extremely slight impairment of the function of the arm. In one case I recently removed nearly the entire pectoralis major muscle, and subsequently the patient only felt some very moderate inability to press the opposite deltoid region as firmly as before.

So far all is plain sailing, even for a beginner in surgery.

The entire breast, and its probably affected subjacent tissue, has been freely removed, let us say. The hemorrhage resulting is easily checked by clamps, which can be left on till the rest of the operation is completed, and by this means alone all bleeding will probably be controlled. If not, torsion will generally accomplish the end aimed at, and only rarely will a ligature be required. The clearing out of the axilla, which next should be done, is not a difficult procedure either, providing certain rules that are now commonly followed by surgeons are employed, the principal one of which is that the axillary vein should be exposed at the beginning of this procedure. This bugbear to the young surgeon is easily overcome, thanks to Bickersteth's and Volkmann's directions. These are in substance as follows: After the original incision

through the skin and subcutaneous fat previously described (which can, however, be altered in the mammary portion according to the various situations of the carcinomatous growth) has been made along the line of the pectoral muscle and the diseased breast properly removed, there will be seen, just below the lower border of this muscle, in the axilla, a thin layer of fascia which is readily recognised (Fig. 1). This axillary fascia can be further exposed, if necessary, by a moderate dissection along the posterior edge of the incision up to the latissimus muscle. A few touches with the knife will now set plainly into view nearly the full width of the axilla, hemmed in by this layer of fascia, which stretches from above the vessels and is adherent anteriorly to the whole external border of the pectoralis major muscle. The position of the artery underneath is not seen, but it is readily felt, and below this point an opening is made in the fascia either by a touch of the knife or by tearing through it with the end of a blunt pair of scissors, whereupon it can be divided through a distance of two or three inches up to the pectoral border. The fat beneath being gently torn through with the finger, or the end of the scissors, will immediately reveal the blue, large, axillary vein. This having been cleared of the loosely adhering fat, though sometimes adhering glands complicate the manœuvre, the anterior attachment of the fascia along the pectoral muscle is then divided throughout, from above downward, and the fat of this space, working from the vein downward and outward, is, as a rule, readily dissected out from this cavity.

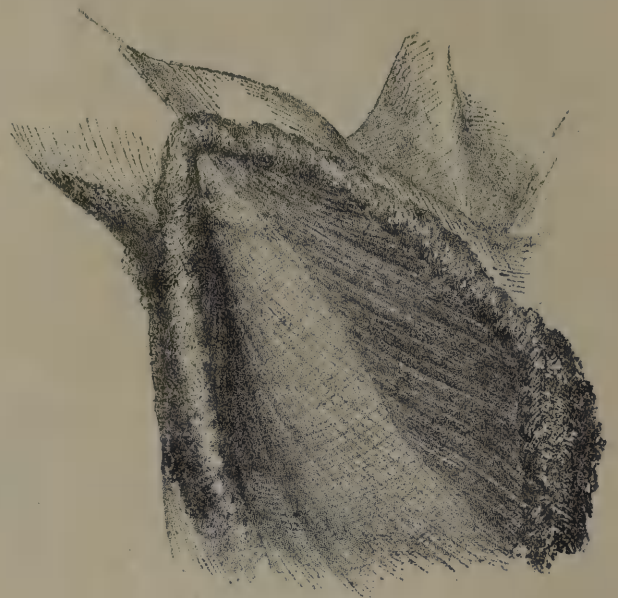


FIG. 1.—Axillary Fascia.

Usually a few small veins and several thoracic nerves will traverse the mass of fat, and these are generally sacrificed. The intercostal humeral nerve, also stretching across the same, generally demands its severance, though, as in some cases where but slight glandular involvement is met with, this can be spared. Following in this way along the chest wall, one comes, proceeding backward, down to the subscapular muscle and to the subscapular vein as it runs into the exposed axillary vein. Here will be found, adjacent to this vein and running from above downward and outward, the subscapular artery, and, what is of great importance to us, as shown by Küster, of Berlin,² the second subscapular nerve (Fig. 2). This it is very desirable, should be spared from injury, for it and the third subscapular nerve, not often seen in these operations, and lying more to the outside, supply the teres major and latissimus dorsi muscles. Its incautious severance is a common cause of the subsequent inability to raise the arm after these operations. It is easy to avoid damaging it, when once on the look-out for it.

In this way the axillary fat, sparing this nerve, can be enucleated from the subscapular muscle up to the edge of the latissimus dorsi muscle, where a few snips of the scissors or cuts with the knife will sever the axillary fat from its posterior and outer attachments in such a manner that it can be removed *en masse* with the fat tissue of the previously detached breast. Individually, however, I prefer to remove the breast completely as the first step of the operation, and

¹ Medical News, October 31, 1891; British Medical Journal, May 7 and 14, 1892.

² Centralblatt f. Chirurgie.

then to take out the axillary fat. After the removal of the fat and gland from the axilla there will be left quite a pocket, at or near the bottom of which, and posteriorly, it is wisest to make a drainage opening.

Should an involvement of the vein wall be discovered one should not hesitate to sacrifice the vessel by removing the diseased portion after ligating above and below the affected part. Should, by any mishap, the rare accident of damaging the otherwise healthy vein take place, it is best closed, if a very small opening, by a lateral ligature; if an opening of any size exists, its closure is best effected by several interrupted silk sutures.

To lend further security to the clearing out of the axilla, an expedient which I have employed now for many years should, in my judgment, be always resorted to. It is, to explore higher up in the axilla that space called by the Germans Mohrenheim's, represented also in Fig. 2, and situated just below the clavicle. This is accomplished by separating with the fingers the cellular plane between the pectoralis major and pectoralis minor muscles, until the clavicle is felt, and then by flexing the arm somewhat upon the chest the pectoralis major muscle itself is lifted up by the fingers of an assistant or by a retractor. By so doing, this space, containing the axillary vessels and a small amount of fat, is readily exposed to view and to palpation. In it will often be found, if



FIG. 2.—Showing the Second and Third Subscapular Nerves, with the axillary contents turned outward, and also the exposure of Mohrenheim's subclavicular space. The axillary artery and nerves are not bared, however, during a mammary amputation.

enlarged glands have been met with in the axillary fat, one or more small-sized carcinomatosely involved glands. With the fingers, and sometimes the end of a curved blunt scissors, not by cutting, this fat can be entirely removed. If any difficulty in so doing occurs, the finger passed underneath the pectoralis minor muscle will crowd this fat sufficiently forward to bring it entirely within the control of the surgeon. I venture to repeat that this is a region the exploration of which I have for a long time insisted upon as being of great importance. Its investigation has not usually been dwelt upon, but I cannot but feel that its systematic examination will lend additional security to the patient. The separation of the two pectoral muscles likewise often reveals a diseased lymph-vessel running alongside the cephalic vein.

The drainage tube, preferably a glass one, is carried in through the skin opening, either under or above the pectoralis minor muscle, and the wound then closed throughout by a few silk-worm-gut sutures, to which are added multiple sutures of the finest silk. Occasionally iodoform gauze is substituted for the drainage-tube—for drainage-tubes do not drain long, as they soon get choked up and the exit of the wound secretion is generally, after a few hours, only accomplished by the space outside the drain. Careful pressure of the replaced flaps of skin, if they come together, is made by wet or dry aseptic towels, or otherwise, during the suturing. The accumulation

of blood and the formation of a blood-clot is not encouraged. The customary antiseptic dressing is applied and secured by broad cotton flannel bandages, and finally fixation of the arm and forearm is carried out as thoroughly as possible.

An operation thus conducted, though much larger than is usually planned, is singularly free from mortality. Of one hundred and twenty-five primary operations conducted in this manner I have not had a single death. In seventy cases operated upon by the older methods I have had two deaths, one from thrombosis of a damaged axillary vein, and the other from erysipelas. Dennis, in seventy-one cases, had but one death. Schmidt's later cases showed but two per cent. of mortality. As to the effect of such or similar thoroughness as this upon the ultimate results the figures presented are encouraging. Twenty per cent. of the cases operated on are reported by Schmidt as cured; twenty-five per cent. of similar cures are given by Dennis. My own data give me in sixty traced cases nearly twenty per cent. of cures. By this is meant that no recurrence has taken place within three years from the date of the operation, a generally received indication of a permanent successful result though not an absolute one. The very late recurrences, such as are occasionally met with, which I have seen, for example, in one instance, taking place sixteen years after the operation, in another case twenty years after the operation, are to my mind more likely to be explained in view of the increasing probability of the protozoal origin of cancer by a reinfection than by a recurrence of the primary disease.

SPONTANEOUS CURE OF MULTIPLE PAPILLOMATA OF THE LARYNX AFTER TRACHEOTOMY.

WITH THE RARE ANOMALY OF PAPILLOMA OF THE EPIGLOTTIS.

By JOSEPH A. WHITE, A.M., M.D., Senior Surgeon to the Richmond, Va. (U.S.), Eye, Ear, Throat, and Nose Infirmary.

[Read in the Section of Laryngology and Otology at the Forty-third Annual Meeting of the American Medical Association, held at Detroit, Mich., June, 1892.]

FRANK B—, aged five years, was brought to me on June 11, 1886, suffering with dysphonia and severe attacks of dyspnoea. I had no difficulty in making a laryngoscopic examination, and found his trouble was due to the presence of several small growths of the larynx, located especially on the left cord and ventricular band near the commissure, and also at the inter-arytenoid space. After two or three sittings to accustom the larynx to the contact of the forceps, I succeeded in removing the obstructions, and cauterising their seats with chromic acid. In October he was brought back because of the return of dyspnoea, and I found the growths had not only recurred, but also had extended to the right side. I also noticed a small protuberance on the lower face of the epiglottis on the right side, as if a similar neoplasm were developing there. October 10, I operated with the forceps, removing most of the growths. November 14, he came back with a more decided recurrence, a regular cauliflower mass, and with the protuberance on the epiglottis developed into a small pediculated tumour. I again removed all the growths, and, fearing they might be malignant, I sent one specimen to Dr. William M. Gray, the pathologist of the Army Medical Museum in Washington, and another to Dr. George Lefferts, of New York. The former replied that the growth was a hard papilloma, composed of squamous epithelial cells, and histoid in character. Dr. Lefferts answered, November 16, 1886, that the growth was a papilloma, and that there was no reason why it should not be radically extirpated, although he did not think this could be done *per vias naturales* in a child only five years of age, and suggested thyrotomy as the best means to that end. He added, "I have never seen, heard, or read of a papilloma of the epiglottis."

My reply to this was to send him the growth that had been removed from the epiglottis, and preserved in a solution of chloral.

He wrote me again, January, 1887, stating that the gross appearance of the little tumour sent him certainly resembled papilloma, but that his eyes then debarred him from the use of the microscope. On January 11, 1887, the case again returned, with oppressive breathing, and the larynx filled with a cauliflower excrescence. Removal *per vias naturales* was followed by relief. This time I could not remove all the growth, and on January 23rd, at 12.30 a.m., I was summoned to go to the boy, a mile in the country. On my arrival, I found the resident physician of the Confederate Soldiers' Home, Dr.

Franklin, endeavouring to resuscitate an apparently dead body. There was no perceptible respiration, the pulse could not be detected at the wrist, and the only evidence of life was a feeble heart-beat.

I opened the trachea by the inferior method of tracheotomy as rapidly as possible. When the air was admitted there was no inspiration and no cough from irritation of the trachea. Artificial respiration was commenced and kept up continuously about three hours. Any cessation of it was followed by disappearance of the apparently respiratory action. The trachea was opened at one o'clock, and consciousness returned about 8 o'clock a.m. The boy recovered rapidly from the effects of



FIG. 1.—In June, 1886.

the asphyxia and the operation, and two weeks later came to my office. I removed the growths again, and repeated the operation several times in the next six weeks. Each operation seemed to be followed by rapid repullation of the growths, and in March they projected above the level of the cartilages of the larynx, preventing the epiglottis from closing the latter. They also extended sub-glottically down to and out of the tracheal opening when the tube was removed to be cleansed. I several times passed a wire loop through the external opening in a small rubber tubing up and out through the mouth, cutting off pieces of the growth from the sub-glottic region. I have also seized them, and drawn them out through the opening in the neck. These operations were repeated from time to time, until I filled a half-ounce bottle with the tissue. Microscopic



FIG. 2.—In November, 1886.

examinations months after showed the character of the tumours to be unchanged.

At last I became disgusted with my results. I recognised that the more I meddled with the case the more abundant became the pathological formations. Several times I was about to adopt Dr. Lefferts' suggestion to perform thyrotomy, but I was averse to doing this, as the voice invariably suffers, and I was not satisfied it would prevent a recurrence.

During the summer of 1889 I was absent a great deal. The

boy came to my office and missed me several times, so that two or three months passed without my seeing him. When I did so, I noticed the mass had diminished in size. So I concluded to let him alone as far as instrumental interference was concerned. He came to see me now and then. I did nothing but look at his larynx and use a simple astringent spray. Under this "do-nothing treatment" he generally improved, the mass constantly diminishing until the larynx began to assume something of a normal aspect.

The growth on the under side of the epiglottis also diminished *pari passu* with the laryngeal neoplasms. In April, 1892, I exhibited the case to the Richmond Academy of Medicine and Surgery, several members of which who give some attention to laryngology examined him. His condition then, as now, was an almost perfectly normal larynx, with white pearly cords, a small projection on the epiglottis at the seat of the former papilloma, and a larger remnant of the growths on the anterior wall of the trachea, just below the commissure. He still wears the tube on account of the latter abnormality. I am afraid to remove it until this disappears. But instead of a full tube, he wears only a piece of a hard rubber tracheal canula, cut off just long enough to keep the opening in the neck patent. At night he wears the inner tube; in the daytime he removes this and keeps the outer tube closed with a cork; and when thus corked up, he can breathe well and speak distinctly the voice being strong and natural. To hear him speak, one would not know he had a tube in the neck.



FIG. 3.—In March, 1887.

This case is especially interesting for several reasons:—

1. It is, as far as I can discover, the first case on record of papilloma of the epiglottis, for although Uchermann reported a similar case to the Christiania Medical Society in 1889,¹ the date of my correspondence with Dr. Lefferts antedates this report fully two years. In his case the growth originated from the epiglottis and vocal cords in a child seven years of age, who had been aphonic four years. He extirpated it entirely in six sittings, and had a perfect result, with no recurrence.

Eliasberg in 1889 also reported one of secondary papilloma of the epiglottis, in his case of recurring papillomata of the larynx in the case reported below. Dr. Louis A. Bull, of Buffalo, N.Y. (*Jour. of Ophthal., Otol., and Laryng.*, July, 1889), records a case of what he calls papilloma of the epiglottis and base of the tongue, but it appears to have been an overlapping of the lingual tonsil.

2. It is the sixth case in literature of spontaneous cure of recurring multiple papillomata of the larynx after tracheotomy, the other five being two cases by Professor Oertel, quoted by Hoppmann (*Volkmann's Sammlung. Klin. Vorträge*, No. 315); one by G. Hunter Mackenzie (*Lancet*, April 6, 1889); one by Eliasberg (*Meditsinskoia Obozrenie*, 1889, No. 1, p. 46); and one by Garel (*Annales des Maladies de l'oreille et du larynx*, June, 1891). In Mackenzie's case the boy was five years old, and wore the tube one year after the operation, which was done in 1883. Eliasberg's case was a boy ten years of age. Thyrotomy was performed in 1887, a mass of polypoid growths removed and cauterised with Paquelin's cautery. In February, 1888, there was a recurrence. In April following thyrotomy was again performed. In June there was a second

¹ See report of the Christiania Med. Soc., Medicinsk Leistabs Fordhandler, 1889.

recurrence, occupying vocal cords and epiglottis. In June, 1888, alarming asphyxia necessitated tracheotomy, and a month later the neoplasm filled the larynx. Two months later this began to improve, and in December nearly all the growths had disappeared.

The canula was worn until March, 1890, when it was removed, as it caused irritation, with bleeding granulations about the wound, and cough. The voice became very harsh, because of the thyrotomies previously performed.

Garel's case was a girl of four years who was tracheotomised after an attack of suffocation, June 11, 1890. The presence of papilloma in the larynx was demonstrated by laryngoscopic inspection. The tube was removed July 30, forty-nine days after the operation, all signs of the growth having disappeared.

Garel also speaks of another case in which he did tracheotomy on a boy eleven years old for presumed growth in the larynx, but as he was unable to see into the windpipe, the diagnosis was doubtful. In all of these cases there was the same result—a spontaneous disappearance of the growths, following tracheotomy, although in each one the tube was worn during a different period. Garel's case was the shortest (forty-nine days), and mine was the longest (five years). Eliasberg's case resembled mine more closely than any of the others.

There was the same tendency to repulsion of the papillomata after each attempt at their removal, the same enormous development of the growths almost immediately following the tracheotomy, and the same gradual shrinkage of them when all operative interference ceased.

3. It shows that the tracheal canula can be worn indefinitely without secondary paresis of the vocal cord, or impairment of the voice, and that in such cases it is best not to be in a hurry to remove it, because of the probable development of tracheal polyps after the operation. In this case they developed even after the larynx was clear of any abnormality, and he still retains the tube, because there is a small remnant on the anterior wall of the trachea.

These growths are of two kinds: 1. Vegetations existing while wearing the tube and retarding its removal; and 2, growths appearing after the removal of the tube and healing of the wound; but the latter danger is only to be feared when we are in too great a hurry to get rid of the tube. Sometimes if their pedicle is weak they may be coughed out; otherwise a secondary tracheotomy may be necessitated by the consequent suffocative spasms, and death may result from one of these attacks before the operation can be performed. That this is no imaginary danger is shown by the fact that over twenty cases have been recorded, by Gigon (*Union Med.*, 1862), Wanschier (*These de Copenhague*, 1877), Archambault (*France Med.*, 1879), Voight (*Jahrb. für Kinderheilk.*, 1882), Kock (*Arch. für Chirurg.*, t. xv.), Waldsberg and Reedel (*Deutsch. Zeitsch. für Chirurg.*, t. xv.), Kohl (*Thèse de Zurich*, 1887), Hume (*Cleveland Med. Gaz.*, 1886), Revilloid (*Rev. Med. de la Suisse Romande*, March, 1891), and others.

The risk of a too early removal of the tube is also shown by a case recorded in one of the last numbers of *The Journal of the American Medical Association*, April 30, 1892, by Dr. F. G. Raynor. A girl of twelve with laryngeal growths was tracheotomised during an attack of suffocation by Dr. Sherwell, Nov. 9, 1889. On the 20th, thyrotomy was performed and the larynx thoroughly cleaned out. Two days after the tube was removed. June 5, 1890, seven months after, she died in a suffocative attack before assistance could be obtained. Had the tube been worn long enough to be sure there would be no recurrence, the result might have been more favourable.

4. The result in my case helps to show the advantage of tracheotomy over thyrotomy in recurring papillomata of the larynx. Some writers claim the latter operation to be free from danger to life and even to voice if properly done, but I doubt if statistics bear out this assertion.

A. Malthe (*Norsk Magazin for Lægevidens Kaben*, 1886, p. 490) reports a case in a four-year-old boy of multiple papilloma of the larynx, tracheotomised June, 1883. On August 15, thyrotomy was performed to remove the growths, and on August 20 the child died. Salzer (*Langenbeck's Archives*, Band 39, Heft. 2), in his report of the laryngeal operations in Billroth's clinic from 1881 to 1889, records ten cases of thyrotomy with three deaths. These references prove it is not free from danger to life, and it is an untenable claim made by Shalita, of Kiev (*Uratch*, 1889, No. 17, p. 389), that it will not affect the voice if properly done. I doubt if any of us has ever performed it without detriment to the voice.

Bornemann (*Deutsch Med. Wochens.*, 1891, No. 15), in reporting four cases of multiple papillomata in children from B. Fraenkel's clinic in Berlin, in three of which thyrotomy was done, and in one (6 years old) an endolaryngeal operation was successfully per-

formed, claims that the latter method is preferable to the former, because of the danger to voice and life from thyrotomy. Tracheotomy has the great advantage over thyrotomy that it gives perfect rest to the larynx, by temporarily suspending its respiratory functions, thus in all probability removing some irritating factor in the redevelopment of the growths, whilst guaranteeing unimpeded respiration without risk of suffocation.

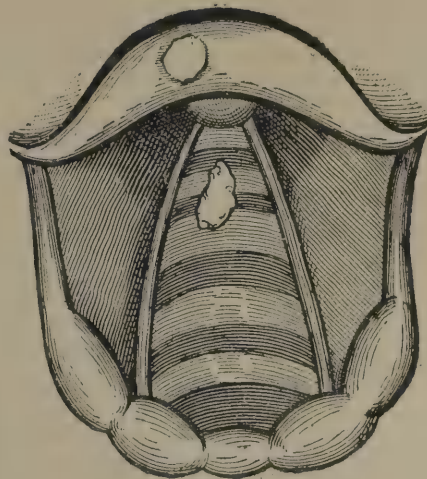


FIG. 4.—Status Praesens.

Thost ("Ueber papillom in der oberen Luftwegen," *Deut. Med. Woch.*, May, 1890), in a capital article on this subject, states that papillomata of the larynx in children will always disappear spontaneously if let alone; that it is benign neoplasm, and without danger. If this is correct, why should thyrotomy with its attendant risks to life and voice be performed? Is it not better to let such cases alone, merely keeping them under observation to guard against suffocation from any sudden or unusual excessive development. It is only in these exceptional cases that tracheotomy is called for, and it will be all the surgical interference required. Malignant growths in children are rare, and these proliferations of the mucosa, as papilloma are claimed to be in contradistinction to organised tumours, are comparatively free from danger. Their causation is uncertain, but any direct irritation of the laryngeal mucosa can produce them. Probably they often result from naso-pharyngeal secretions dropping into the larynx at the arytenoid space, and which, not being coughed away, act as a local irritant.

Lennox Browne ("A case illustrating the possibility of hypertrophy of the pharyngeal tonsils being an etiological factor of papillomata in children," *Brit. Laryng. and Rhinolog. Assn.*, Nov., 1890) reports a case upon which he bases an argument to show that adenoids of the naso-pharynx are a factor in their production. This is probably true, as adenoids are accompanied by considerable secretion which may drop into the arynx, and keep up a prolonged irritation of the mucosa.

THE BEST NUTRITIVE ENEMA.

EWALD, as a result of experiments, found that eggs, even though not peptonised, were to a considerable extent absorbed by the rectal mucous membrane. According to the *Mercure Medical* for April 1st, Huber, of Zurich, has recently repeated Ewald's experiments in Professor Eichorst's clinic, and announces that the absorption of raw eggs is greatly aided by the addition of common salt. The salt is well borne, and causes, as a rule, no irritation of the bowel. He considers that eggs beaten up with salt, in the proportion of fifteen grains to each egg, are the best for nutritive enema. His method of procedure is as follows: Two or three eggs are taken, and thirty to forty-five grains of salt are added. They are slowly injected by means of a soft rubber tube, carried as high up the bowel as possible. Three such enemata are given daily. An hour before each enema the rectum is cleaned out by means of a large injection of warm water. Any nutritive enema will be better absorbed by being peptonised, which may be readily done by the addition of from five to ten grains of Lactopeptine powder.

MEDICAL LITERATURE.—II.

A BOOK OF THE MONTH.

Manual of Bacteriology. By A. B. GRIFFITHS, Ph.D., F.R.S.E., F.C.S. Pp. 348. (London: William Heinemann, 1893.)

[Specially reviewed for MEDICAL REPRINTS by EDWARD A. PIGGOTT, L.R.C.P. and S. Edin., L.S.A. Lond.]

THE last decade has witnessed such vast progress in the methods and aims of scientific research, more especially in the domain of pathology, that the student of to-day, were he not well acquainted with the elementary principles, *i.e.*, the germ theory of disease, as exemplified in some of the lowest forms of life—bacteria—would (according to certain pathologists) be at a loss to comprehend the causes of all communicable or contagious diseases. We therefore gladly welcome the work under consideration—the fifth of a series of scientific hand-books published by Mr. Heinemann, and bearing the title of “A Manual of Bacteriology,” by Dr. A. B. Griffiths.

The volume appears to be a most useful epitome of the science of bacteriology or, in other words, the study of microbes. The work certainly commends itself as much to the intelligent householder as to the scientific reader, the subject matter being, to both alike, of vital importance.

The introductory article, after explaining, according to the canons laid down by Dr. R. Koch, as to whether a microbe is, directly or indirectly, the *causa causans* of any particular disease, proceeds to impress upon the reader the necessity for the observation of, and experiments upon, living matter, if bacteriology is to be of any utility as applied to the investigation of disease. This condition at once brings us face to face with the much-disputed question of vivisection, concerning which I cannot do better than quote the author's words:—

“Vivisection is necessary for a proper interpretation of the phenomena. But every now and again a loud outcry is raised against this method, partly from ignorance and partly from prejudice. Many—probably most—of the opponents of experiments on animals are good, honest, kind-hearted people, who mean well, but either forget that man has rights against animals, as well as animals against man, or are misled by the false statements of the other class. These are persons who, blinded by prejudice, regard human life and human suffering as of small importance compared with those of animals, who deny that ‘a man is better than many sparrows,’ and who, to the question that was put of old, ‘How much, then, is a man better than a sheep?’ would return the reply, ‘He is no better at all.’ Such people bring unfounded charges of cruelty against those who are striving, to the best of their ability, to lessen the pains of disease both in man and also in animals, for they, like us, are liable to disease, and, like us, they suffer from it.”

The first, or introductory, chapter concludes with details respecting the general properties of microbes, their structure, contents, &c., also their reproductive power, which is said to be enormous.

Chapter II. is exclusively devoted to a most lucid description of “The Bacteriological Laboratory and its Fittings.” The various instruments and apparatus, such as microscopes, dissecting knives and needles, forceps and scissors, together with Professor Koch's steam steriliser, hot-air sterilisers, Dr. Babes' incubator, Karl Abel's incubator (with thermo-electric regulator), and numerous other requisites for prosecuting scientific research. This chapter is profusely illustrated, and contains, in addition, a general account of the interior of the Bacteriological Laboratory of the Royal College of Physicians of Edinburgh, and the Pasteur Institute, Rue Dutot, Paris.

Chapter III. treats more particularly on the different methods of cultivating microbes, the necessary manipulations for staining and mounting them for microscopic inspection, and the methods of introducing them into living animals. “In such experiments guinea-pigs, rabbits, mice, fowls, &c., are used. Pure cultivations of microbes and infectious matter are introduced into the animal body by the following methods:—

- “(a) Inhalation.
- “(b) Swallowing.
- “(c) Direct inoculation.
- “(d) Special operations.

“(a) An animal is made to inhale the infectious matter, &c., disseminated by means of a spray;

“(b) The infectious matter is mixed with the animal's food;

“(c) The infectious matter is introduced into the animal body by cutaneous or subcutaneous inoculation or injection;

“(d) By the fourth method mentioned above (*i.e.*, special operations), the infectious matter may be injected into the duodenum, or introduced into ‘the peritoneal cavity by the performance of abdominal section.’ These and other operations are used as means of introducing microbial matter into the living animal. But it cannot be too firmly impressed upon the mind that all operations should be performed with antiseptic precautions, and the instruments, as well as the hands of the operator, should be thoroughly disinfected.” The chapter closes with a few remarks on the *unit of microscopical measurement*.

The Author, after referring to the equivocal origin of microbes, as distinguished from their spontaneous generation, states as follows:—

“If microbes originate from putrid matter through equivocal generation, putrefaction must appear before the microbes; but experience shows the contrary, that putrefaction is a consequence of the development and growth of microbes.”

“The triumph of modern knowledge is a knowledge—which nothing can shake—that Nature's processes are immutable. The stability of her processes, the precision of her action, and the universality of her laws, are the basis of all science, to which biology forms no exception. Once establish, by clear and unmistakable demonstration, the life history of an organism, and truly some change must have come over Nature as a whole if that life history be not the same to-morrow as to-day; and the same to one observer, under the same conditions, as to another.”

The concluding remarks of this chapter are explanatory of microbial classification.

A considerable portion of the work (Chapter V.) is now reserved to the description of most of the more important microbes. Bacteria and bacilli, inclusive of vibrios, spirilla, spirochaetæ, yeast fungi, &c.—for complete account of which I must refer the reader to the work itself—for verily their name is legion!

We now pass on to the latter, and, to the medical reader, more interesting portion of Dr. Griffith's Manual. Chapter VI. being dedicated to the consideration of “Infectious Diseases and Microbes.” The micrococci of yellow fever, hydrophobia, erysipelas, puerperal fever, influenza, pneumonia, scarlatina, syphilis, tetanus, malaria, typhoid fever, cholera, diphtheria, tuberculosis, anthrax, and several diseases of less import, are treated in a thoroughly comprehensive manner, a few extracts from which I will reproduce.

Under Hydrophobia the most precise instructions are given for the preparation of the inoculating fluid or virus, also for its ultimate application in accordance with the laws laid down by Pasteur. Great stress is attached to the fact that “Pasteur's treatment is prophylactic and not curative, for it is powerless against the disease when the first symptoms have once made their appearance. Hence the necessity of early treatment.”

Interesting details are given concerning puerperal fever, notwithstanding the fact that the microbe or microbes producing the symptoms in this disease have not as yet been isolated. Speaking of this disease the author says: “It may be stated that the introduction of the antiseptic and aseptic methods has produced not only a remarkable diminution of mortality, but also of the morbidity or illness incident to the puerperal state.”

Here follow some interesting tabulated statistics relative to the mortality from puerperal fever before and after the introduction of antiseptics.

Influenza, or as the French term it *la grippe*, as a matter of course claims a certain amount of attention, although the microbe is as yet undiscovered.¹ It is, however, highly probable as Dr. Griffiths suggests, that the causation of this disease may yet be traced to some endemic source.

“There are many reasons for thinking that the contagium of influenza is borne through the air by winds rather than by human intercourse. One reason for thinking so is that it does not appear to travel along the lines of human communications, and, as is seen in the infection of ships at sea, is capable of making considerable leaps. Dr. Parsons, on the other hand, believes that the epidemic is propagated mainly by human intercourse, though not in every case necessarily from a person suffering from the disease.”

Under scarlatina we have the fact that Dr. Klein found

¹ “Appendix.—Under ‘The Influenza Bacillus’ appears the following statement:—Drs. Pfeiffer, Kitasato, and Canon, have (independently of one another) discovered the influenza microbe. It has been found in the saliva and the bronchial discharges characteristic of influenza.”

Micrococcus Scarlatinae in the blood of scarlatina patients, both during life and after death. Attention is also directed to the fact that cows are liable to be attacked with the disease, and that the milk of the cow so affected is capable of producing scarlatina in the human subject.

Cholera is the subject of a lengthy article—and deservedly so—especially as there is every probability of a recrudescence of this dire disease in the ensuing spring and summer months. I therefore quote the following extracts:—

"Since 1848, many scientists have been at work trying to establish a specific cause of cholera; but it was not until 1884 that Dr. R. Koch discovered the comma bacillus in choleraic dejecta, &c. Although many distinguished pathologists have not accepted Koch's evidence of the bacillary nature of Asiatic cholera, there can be no doubt, after the important and extensive researches of Drs. Macleod and Milles, that the comma bacillus of Koch is the cause (directly or indirectly) of Asiatic cholera."

"Koch's *Spirillum Cholerae Asiaticae* is always present in Asiatic or malignant cholera, and it has not been found apart from this disease, and disappears from the body with the disease. Its *habitat* is the intestinal canal, and the detection of this bacillus enables the physician more readily to diagnose the earliest cases in an epidemic of cholera."

Particular attention is called to the fact that cholera, like typhoid fever, is largely disseminated through the medium of the water supply.

Under chapters VII., VIII., IX. the microbes of the air, of the soil, and of water are discussed. When speaking of the air, reference is made to the enormous number of dead or inorganic particles contained therein: "It is stated that a man in the town inhales about 37,500 germs every twenty-four hours, and no fewer than 2,250,000 inorganic particles every minute.¹ Most of these are merely annoying, though a few are real messengers of disease and death."

The space at my disposal for this review precludes me from following the author in his manipulative operations for estimating the number of microbes in a known volume of air. Suffice it to say that they are very complete, and will well repay perusal and careful study. The same may be said of the articles on soil and water, the last-named being most instructive.

The remainder of the volume is devoted to the consideration, more or less in detail, of the ptomaines and soluble ferments, germicides and antiseptics; the work concluding with an appendix and copious index. It is embellished throughout with good illustrations, and the type is excellent.

BOOKS.

[Works for notice under this heading should be addressed to the Editor at 46, Holborn Viaduct, not later than the 8th of the month. Publishers will assist the Editor and reviewers by stating the price of every publication forwarded.]

THE fourth edition of Mr. George P. Field's "Diseases of the Ear," with many additions, and some coloured plates, is just to hand (London: Baillière, Tindall and Cox, 12s. 6d.). One novel feature of this most valuable and practical work is the ingenious use of cardboard for some of the plates. The spot where the membrana tympani ought to be seen is perforated, and a coloured representation of the drum is pasted on behind. If the membrana be looked at through a speculum a more correct idea of the actual appearance of the parts than any heretofore given will be the result. The vast clinical experience of Mr. Field makes this a work perfectly indispensable to the general practitioner seeking a knowledge of aural therapeutics.

WE have also received a useful monograph, which has just reached a seventh edition, in Dr. Thudichum's work on "Polypus and other Nasal Diseases," as treated by Electro-cautery and other modern methods (same publishers, 2s. 6d.). Apart from the careful accuracy of which the name of the author is a sufficient guarantee, the work derives a special

value from the fact that it is based entirely upon original research and direct clinical experience.


PROFESSOR ADAMKIEWICZ, of Vienna, has embodied the results of his researches on cancer and its treatment in a work, "Untersuchungen über den Krebs und das Princip seiner Behandlung," which has just been published (W. Braumüller, Vienna). The object of the book is to prove that "cancer cells" are not epithelial cells, and that the inoculation of "cancer cells" in the brain leads to the formation of foci of the disease, and generates a specific poison ("cancerin"). The author maintains that cancer is due to the action of a parasite, which he identifies as *Coccidium sarkolytus*. By the injection of "cancerin" into the subcutaneous connective tissue, he claims to have effected a cure in twenty-five cases of malignant disease.

In an exhaustive pamphlet on the cholera in Egypt, just published by Dr. F. M. Sandwith, of Cairo, there is an interesting account of the sanitary conditions of Mecca and its pilgrims. Mecca has 110,000 inhabitants. The holy season is early in summer, and the number of pilgrims then entering the city varies from 80,000 to 100,000. The town is so crowded that £3 to £4 must be paid for a night's lodging, and thirty people crowd into a small room in order to divide the expense. The houses have cesspools which are seldom or never emptied, and the latrines are too foul to be used. The drinking supply comes from the Ain Zebaida and runs into an open reservoir about three hundred feet in diameter. This reservoir is never cleaned out. It is so contaminated by neighbouring cesspools that the water stinks. It is unprotected, so that people throw in whatever they wish. Mecca stands in a winding valley shut in by rocky hills that fiercely reflect the August heat. Mina is a village three miles from Mecca, and Arafat a mountain twelve miles away. The pilgrims before the sacred rites run seven times between the hills of Mecca, and throng during the day the Kaaba with its horrible air. On the first holy day they go through Mina to Mount Arafat, where they remain all night, with prayers for three hours before daybreak. Then, almost naked, exhausted with fatigue, fasting, and emotion, the pilgrims crowd towards Mina in a confusion and chaos that lasts most of the second night. The third day is ushered in by prayers at dawn, and then some rush headlong toward Mecca, while others gather in a seething mass in a narrow pass to stone the Devil's Pillars. Then some six thousand sheep and cattle are sacrificed in the village of Mina, where no provision of any kind exists for sanitary slaughtering. The air becomes pestilential and prevents sleep at night. Everyone suffers from the heat, stench, blood-soaked earth, vermin, kites, and vultures. The water at Mina comes from the Mecca fountain, and is kept in large cisterns, never cleaned, and full of entozoa. Many pilgrims fly at once to Mecca to escape the horrors of Mina, but numbers are detained, by religious scruples or other reasons, for three days. This state of affairs is quite enough to produce any pest, and the mortality from diarrhoea alone is very great among the pilgrims. Immediately after Holy Week the faithful are enjoined by their religion to disperse from Mecca, carrying with them the germs of diseases as well as any number of internal and external animal parasites. Besides this, those who can afford to do so bring back for their friends and for home consumption bottles of the precious Zem Zem water, which acts as a purge, and tastes and smells horribly. An analysis of this holy water made in London some years ago, showed that it was dangerously contaminated with sewage.

The Mecca pilgrimages are a source of great peril to many Eastern countries as regards cholera. Most of the Egyptian epidemics have had their origin there, although a quarantine has been enforced against returning pilgrims. In 1890 Mecca's cholera mortality while the pilgrims were carrying on their devotions was four hundred to five hundred daily. In 1891 the cholera mortality in the holy city during the performance of the sacred ceremonies by the pilgrims reached four hundred a day. During the last thirty-two years cholera has infested Arabia sixteen times. Egypt has suffered but three times in the same period, probably only because the pilgrimage is so long that the disease dies out before the pilgrims return. From a study of these facts and all the points in relation to India, it would seem that there is no tendency among the picturesquely filthy Orientals to sanitary reform of any kind, and it becomes the duty of Western governments regnant there to protect the civilised world from these barbaric Oriental nests of pestilence.

¹ "A cigarette smoker sends no fewer than 4,000,000,000 of particles (more or less) into the air with every puff he makes."


PUBLISHER'S NOTE.

 MEDICAL REPRINTS will be sent, *post free*, to the address of any medical man for twelve months at a subscription of two shillings and sixpence per annum.

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

MARCH 15th, 1893.

ALTHOUGH it is generally assumed to be true that variola and vaccinia are manifestations of the same virus, the scientific evidence upon which this doctrine rests has often been called in question. In a recent issue of *The Revue Scientifique*, the subject is once more discussed in the light of new experimental research. As late as 1891 Chauveau asserted that it was impossible to produce cow-pox by variola. This French observer stoutly maintained that

each of these diseases had its separate virus, even if originally the same micro-organism might have caused them. But in a recent article appearing in *The Revue Médicale de la Suisse Romande*, Drs. Eternod and Haccius have formulated a series of conclusions which tend to re-establish the older view concerning the true variolous nature of the vaccine disease. The conclusions referred to are about as follows, and represent the results of recent experimental inquiry:—

1. Variola is communicable to the bovine species by inoculation, provided proper precautions are taken.

2. True variola inoculated upon calves can be propagated, but changes in character in later generations, and at length assumes the features of ordinary vaccine disease. Both as regards clinical symptoms and pathological lesions, this gradual change never fails to appear.

3. This variola vaccine acts like ordinary vaccine virus both upon man and calves. It produces a benign local vesicular eruption, identical with that seen after vaccination.

4. Inoculation with variola vaccine renders ordinary vaccination inoperative, and probably confers immunity from small-pox.

5. The degree of virulence of variola vaccinations is reduced by successive removes through fresh calves.

6. As to the duration of immunity conferred, and other practical inferences to be drawn from their experiments, the authors are awaiting the results of further experience.

7. The original identity of cow-pox and small-pox, while probable, is not absolutely certain.

8. Whether or not the change from variolous virus to variola vaccine is one of mere attenuation or radical alteration, is not yet clearly established by their personal experiences.

But this identity is claimed to have been demonstrated by Dr. Fischer (*Semaine Médicale*). This author takes the virus of a small-pox pustule at the time of its maximum intensity, and by practising crucial incisions in the calf, raises a crop of typical small-pox pustules in that animal. Moreover, this bovine small-pox can be communicated through a series of animals without diminution of its original power. It can be employed in children, and acts in all respects like ordinary vaccine virus, producing merely a local benign eruption. Dr. Fischer has used the lymph thus obtained in thousands of cases without untoward symptoms of any kind. He believes it to be safe and trustworthy. Thus it would seem that a practical demonstration has been given, showing that the virus of human small-pox can be transformed into that of ordinary vaccinia.

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THE BRISTOL MEDICAL SCHOOL.

NEWS AND NOTES.

THE possibility of a return of the cholera has been quite the question of the month. The Cholera Conference in St. Petersburg, as might have been expected from the conventional lines on which it was conducted and the affectation of official secrecy with which it was surrounded, has, says the *Manchester Guardian*, not been very fruitful in new information. One main and important conclusion was, however, arrived at. This was that (like the great epidemics of cholera in this country studied by Snow and Simon, and the East London epidemic of 1866) the "pollution of the drinking-water was in almost every case the channel by which the disease was spread." The cholera was shown to have followed the lines of human travel, and to have spread along the course of the systems of the Volga, the Don, the Dnieper, &c. This furnishes for the first time the full confirmation from Asiatic sources of the English "water theory" of cholera, the application of which has been so fruitful in life-saving, and in the prevention of the spread of cholera. Steps are being taken to bring these conclusions to the notice of the Government.

ANOTHER congress, attended by thirty-two delegates from the chambers of commerce and commercial corporations of the seaports of the German Empire, was held at Hamburg recently, for the purpose of considering the measures advisable in regard to the sanitary control of home and foreign vessels visiting German ports. The motion put forward by the Hamburg delegates, namely, the adoption of rules analogous to those now enforced in the United Kingdom, which are admitted to have proved in every respect efficient without causing unnecessary interference with marine intercourse, was not accepted in its entirety. An international agreement was not considered to be as yet desirable. The resolutions formulated will be revised by the delegates of Hamburg, Stettin, and Dantzic, for immediate submission to the Imperial

Chancellor for eventual embodiment in the forthcoming Imperial law regarding epidemics.

In the half-yearly report of sickness and mortality among the servants of the East Indian Railway Company, for the first half of the current year, says *The Indian Medical Gazette*, an instructive instance of infection by cholera stools is recorded. Dr. Bathe reports that there can be no doubt that milk diluted with impure water was the cause of the outbreak of cholera last April among the European employes and their families stationed at Asansol. The milk-supply was not equal to the demand, and the only water available for its dilution was procured by digging holes in the bed of a small river, at a spot where the excreta of several cholera patients had only a day or two previously been thrown. Almost all those who suffered from cholera had partaken of this milk. At Jamalpur a native child, suffering from cholera, was seen by Dr. Brooke lying on a bag full of rice, and the choleraic dejecta were soaking through the gunny bag into the rice. Had this rice been sent on to some distant place where no cholera existed, and had cholera supervened on this rice being distributed and eaten, we might have been treated to various theories as to the origin of the epidemic; but it is very doubtful if the simple explanation of the choleraic dejecta of this child would have been hit on.

AND, *à propos* of cholera, and as a curious illustration of a fundamentally correct idea existing in the traditions of a nation, the following passage from Orton's work on "Cholera," published in 1831, is of interest: "The natives of India are an unenlightened race. Some idea of the value of their opinion on any doubtful subject may be formed from the fact of their universally believing that malarial fevers are owing to drinking bad water." Time has justified the Hindoos', rather than Orton's, belief.

THE London correspondent of *The Boston Medical and Surgical Journal* writes that every new game appears to bring with it one or more peculiar and characteristic physical effects or defects. We have heard of the "tennis elbow" and the "bicycle chest," and now an authority in a monthly periodical writes of the "golf straddle, the golf waggle, and the golf twist." The symptoms of these various peculiarities are described so that they may be recognised by even a layman upon the street. If, for instance, a man is seen "coming down Pall Mall with his legs wide apart, his head and shoulders twisted round backward, and his hands aimlessly swaying his umbrella, you know at once what has happened." It would seem a little difficult to tell advanced golf symptoms from a mild case of inebriety.



THE BRISTOL MEDICAL SCHOOL.—ENTRANCE HALL.

OUR ILLUSTRATIONS.

By the courtesy of the Editor and Publisher of *The Bristol Medico-Chirurgical Journal* we are enabled to show this month views (from photographs by Mr. Edwin Gael, of 77, Whiteladies' Road, Bristol) of the new Medical School in that city.

"The new School," says an article in *The Bristol Medico-Chirurgical Journal*, "is built in local stone of a warm, purplish-red colour, the dressings and architectural features being of Coombe Down freestone. The portion containing the large Museum and Library is made to dominate the whole design, and has an imposing gabled front, flanked by turrets with small crocketed cupolas, the Library windows having arched tracery heads of rich pattern. All the remaining windows of the building are square in outline, mullioned, and have small cusped arches in the heads. A fine, deeply-moulded cornice runs round the entire building, broken at intervals by carved gurgoyles, pateræ, and grotesque heads. The walls finish with a battlemented parapet.

"One enters from the road, under a moulded archway through a little lobby enclosed with pitch-pine screen-work, and paved with mosaics, to find oneself in a spacious hall, floored in a similar manner, whence access may be had to the rooms for Faculty meetings and for students on the left hand, and to a doctors' reading room, a cloak room, and a porter's room on the right. At the end of the corridor on the right hand a doorway, in a screen fitted with fine lead glazing, conducts to the Museum, a well-lit room, 50 feet by 30 feet, with a preparation room in connection with it.

"There is a handsome piece of glass by Bell and Son in the staircase lights, which gives the whole staircase a good effect. The design of the balusters and the solid newels is in keeping with the rest of the building, and the walls are cased here, as in most of the rooms, halls, and corridors, with panelled dados of choice figured pitch-pine.

"Ascending the broad, old-fashioned staircase which rises from the hall, we arrive at the first floor, where a Theatre is provided for physiological lectures, a Laboratory properly fitted for physiological work, a small preparation room, and a Library.

"The Library is entered under a richly-moulded arch, with carved spandrels, emblematic of the mysterious principles of life and the healing attributes of the Deity. The room, which is planned and fitted to take the associated libraries of the Medical School and the Medico-Chirurgical Society, is a very handsome one, 50 feet by 30 feet, lit on three sides by mullioned and traceried windows, and dignified by an open timber roof, with panelled compartments, having carved bosses at their intersections, and supported by massive moulded hammer beams, with carved braces and fretted spandrels. These beams rest upon six moulded freestone corbels, bearing shields, on which are cut monograms of initials of some of those who have had a distinguished connection with the School. A handsome freestone chimney-piece, of the old baronial type, stands at one end of the room, and the solid ranges of dark-wood bookshelves complete the circuit of the room. A pleasant effect for reading purposes is produced in this Library by the introduction of cathedral glass in all the lights, a pale green tint slightly predominating.

"At the rear of the building a glazed covered way gives immediate access to the old School, which, with a few necessary internal modifications, has been preserved intact. The Lavatories, which are situated at the end of this covered way, are very complete, and well lit, ventilated, and drained.

"The whole of the new building is lit with gas, the best rooms having powerful sun-burners, with ventilating trunks connected to them, and the heating throughout is by low-pressure hot water. Radiating coils are provided in nearly every room, and wherever else needed, through which continually enters an ample supply of fresh air, warmed to an agreeable temperature."

AMERICAN OPINION.

DIGITALIS IN PNEUMONIA.

DR. R. I. BOND, of Hartshorne, I. T., writes that he has never failed to obtain the desired result from the use of digitalis in pneumonia, if given after the following method:—

"Begin with a medium dose, the fluid extract in preference, and gradually increase until the pulse is reduced to a little below normal, then decrease until the normal pulsa-

tion returns and hold it at that until all expectoration subsides; then gradually decrease until the dose is so small that you can safely stop its administration, convalescence by this time being quite advanced. It will probably be asked what are its effects outside of those upon the heart. It is: 1st. The only permanent antipyretic; 2nd. The only trustworthy sedative; 3rd. The only effectual means of rapidly controlling the flow of blood to the inflamed lung, hence it soon checks expectoration by rendering it unnecessary; and 4th, it has the diuretic effect which is needed in most cases of pneumonia.

The dose is to be measured by the amount of obstruction in the circulation through the lung. I have found it necessary to increase the dose to fifteen drops of the fluid extract every four hours to control the heart's beat in adults where there was extensive obstruction in the lung. I have given to a child four years old four drops every three hours with nothing but the desired effect. This was in a case of capillary bronchitis, in which trouble it is quite as efficient as in pneumonia. A favourite combination is this:

R. Aromatic spirits of ammonia	...	...	ss
Fluid extract of digitalis...	...	...	iiss
Glycerine	...	...	q. s. ad 3 iv

M. S. Teaspoonful every three or four hours, to be increased as the case may require.

BARIUM CHLORIDE IN EPILEPSY.

By JUSTIN D. LISLE, M.D., Springfield, Ohio.

EPILEPSY is one of the oldest diseases known to medical art, and for the relief of it our materia medica is almost exhausted. Remedy after remedy has been tried, only to prove partially satisfactory, if not a complete failure. The silver salts formerly, and latterly the bromides, especially a mixture of the bromides of the alkalies, have met with the most encouragement. Yet with all there is still something lacking. Some years ago my attention was attracted to barium chloride, a salt occupying an insignificant position in our therapeutics. This fact I am unable to account for, except for the reason of its many incompatibilities; consequently it is necessary to administer this drug alone, and in that state it is very disagreeable. Barium chloride occurs in colourless tablets, insoluble in absolute alcohol, freely soluble in water; it is incompatible with sulphates, phosphates, carbonates, and is decomposed by most of the salts of organic acids. Silver nitrate decomposes it.

Writers on materia medica say of barium chloride that it possesses a disagreeable, bitter, astringent taste, and causes a sense of heat and burning at the epigastrium. Active peristalsis of the bowels and copious alvine evacuations are excited. The nervous system of organic life is stimulated; it slows the number of heart-beats, at the same time contracting the calibre of the arteries. Having an action similar to digitalis and ergot, its therapeutic use is confined to the treatment of aneurisms, hæmorrhages, acute congestions, etc. While we hold prominently before us the facts that barium chloride slows the action of the heart and contracts the calibre of the arteries, and that preceding and during an attack of epilepsy, in both *petit mal* and *grand mal*, there is increased action of the heart, dilated arteries, cerebral congestion, and in *grand mal* strong pulsation of the carotids and bulging of the eyeballs—keeping this antagonistic action before us, I should like to give the clinical history of two cases of epilepsy, wherein barium chloride was the only remedy used:

CASE I.—W. P. O., white, male, aged nineteen; occupation, labourer; complexion, dark; constitution and general health, good. Parents healthy, with no history of nervous disease. This patient never had spasms when an infant; no severe injury or surgical operation; habits of life temperate, hygienic surroundings good; a history of moderate masturbation and nocturnal emissions. Has had fits since nine years of age. At first they occurred about once a year. For a year previous to September 5, 1886, has been having *three a week*. The fit is preceded by a peculiar dizziness, lasting for only a moment; when this passes off he feels as well as usual. In the course of an hour he will straighten up, roll his eyes, turn his head towards the right, and fall to the left, and remain unconscious about fifteen minutes. No cry, no biting of the tongue, or frothing at the mouth. The attacks are single, and occur in *daylight* only. Upon recovering he experiences very little muscular soreness. No vomiting. Appetite is good, sleeps fair, and bowels regular.

September 8, 1886.—Commenced the administration of barium chloride—one-eighth of a grain every four hours.

10th.—The patient had a very light fit; has noticed no disagreeable symptoms from the barium.

18th.—Had a very light attack, occurring about nine o'clock in the evening, the first he has ever had after sundown; was unconscious about five minutes. No headache, muscular soreness, or weakness followed; head feels remarkably clear. I now increased the dose to a quarter of a grain every four hours. On September 28 felt his premonitory aura, dizziness, frontal headache, and spasm of the left sterno-mastoid sufficient to turn his head. Took a double dose of the barium chloride (half a grain), and escaped his fit.

October 15.—At 8 30 p.m. had the first fit since September 18. Such is the record of this case up to June, 1887, the fits occurring about once every six weeks. Between June, 1887, and January, 1888, he had three attacks, since which time I have lost sight of him.

In this case there are a few points to which I wish to direct attention. First, the large dose taken upon September 28 without causing gastric disturbance and with abortion of the attack, so strongly predicted by the distinct aura. Second, the change from diurnal to nocturnal. Third, in the description of this patient I stated that he was a "brunette"; it has been a matter of observation with me that out of about two hundred and fifty cases of epilepsy I have never seen a "blonde"; in one case that I knew of the patient originally had brown hair, but it ultimately turned black; what this signifies, if anything, I am unable to state.

CASE II.

C. C. R., white, male, aged fifty years; occupation painter, dark complexion; no history of nervous disease. During the war received a contused wound upon the right side on a line with the middle of the axilla and on a level with the nipples. Between 1864 and 1884 has suffered with *petit mal*, having about three attacks a month, except in extreme hot or cold weather, when they would occur every four or five days. In 1884 he experienced the first seizure of *grand mal*, and from that time averaged three a month. The aura started from the cicatrix from the wound in the side, attracting his attention to that part by fibrillary spasms in the muscles of the right side; the sensation then appeared to travel to the spinal cord, thence to the brain, whereupon he falls to the ground, muscles become rigid, a little froth collects at the corners of the mouth; in his last attack uttered for the first time a "cry." Always feels very sore upon recovering. Attacks usually occur about twilight. On September 7, 1886, I gave him the barium chloride in eight-grain doses every four hours; at the end of a week reports a total disappearance of the peculiar dull feeling in the head and speaks of a remarkable clearness; has a good appetite, sleeps well, and bowels regular. On October 2, 1886, at 5 p.m., felt his aura distinctly; took three-eighths of a grain of the barium and got off without a fit. On October 13 again felt his aura; took half a grain and escaped, but vomited. On December 4 had the first fit since September 7. During 1887 he had three fits, one in April, July, and December, since which time I have lost sight of this case.

Now that the alkali earths are claiming recognition, I feel as though barium was not without some therapeutic value, and should have its share of investigation.

HOW TO CURE ECZEMA.

[From the *New York Medical Record*.]

WE know that the information we are about to give will be eagerly accepted, because of the frequency with which the question is asked. It was only the other day that a practitioner was overheard to inquire of a dermatologic friend, "What is the best thing to do for eczema?" Now he might almost as well have asked, "What is the best treatment for disease of the skin?" since his question only excluded about two-thirds of all cases. Eczema has an ever-present interest for the general practitioner, while it is to him that come the great majority of cases to be treated, and journals devoted to general medical topics are constantly disseminating knowledge for his guidance. In a recent issue of an exchange we find the following, which has already had a good start on its rounds, and will continue to be copied, we presume, until some one pauses to consider, as the editorial scissors are at work, that four drachms of salicylic acid to the ounce is rather strong treatment. Here is the prescription:—

FOR ECZEMA WITH ABUNDANT DESQUAMATION.

(*Therapeutic Gazette*.)

R. Salicylic acid	gr. xv.
Oxide of zinc	gr. xxx.
Vaseline	gr. xxx

Charity forces us to the conclusion that in the original an ounce of vaseline was written or intended.

Still in the same journal we find the following:

PRURIGINOUS ECZEMA.

R. Oxide of zinc, vaseline equal parts.

It may be well to incorporate with these, if pruritus is present, a little oil of peppermint or carbolic acid, in the proportion of 1 to 4.

This would make it appear that the [recommendation of] zinc and vaseline in equal parts was intentional in the first prescription. But

why call twenty-five per cent. carbolic acid "a little"? and in what forms of pruriginous eczema is pruritus likely to be absent?

The fact that there are so very many kinds of eczema, some depending on local, others on general, conditions; some sharply limited, while others extend over the entire surface; some simple, and others due to an association of etiological elements, renders any attempt to generalise as to the treatment of eczema a difficult, and usually a futile, task. Take, as an instance of a single regional division, eczema of the lips. Before we can enter upon a rule of treatment, we must further subdivide the subject into those forms which begin upon the skin proper, and those affecting primarily the vermilion border or mucous surface. Of the former we have the quite common eczema which appears beneath one or both of the nostrils, depends upon a discharge from them, simulates a sycosis, and is in all probability of parasitic nature. In such an instance the eczema is cured and recurrences prevented principally by treating the chronic coryza or other nasal trouble present. Another variety is that seen in infants, and attributed to a strumous diathesis. Here, certainly, remedies directed to the constitutional disorder form the appropriate treatment. Seborrhœal eczema of the lips, whether beginning at the junction of the skin and mucous membrane, or affecting other



THE BRISTOL MEDICAL SCHOOL.—LECTURE THEATRE.

parts primarily, constitutes a rebellious disease, which may have to be combated with resorcin, sulphur, salicylic acid, citrine, or other ointment, for a long time, and may then not succumb without the aid of arsenic, cod-liver oil, or other internal agents.

Other forms of intensely itching dry and scaly labial eczema may be encountered, sometimes due to one cause and sometimes to another, and each particular case will have to be treated on its merits.

Marchand (*Thèse de Paris*) calls certain of these cases *Eczema de la Moustache*, which is not quite so bad as the term used by a well-known oculist of this city, who, in sending a patient to a skin specialist, wrote: "I send you a case of moustachitis." Here again the question arises, Shall the lip be shaved, or the hairs clipped short? Shaving will, as a rule, be found too painful, if there is much infiltration and inflammatory reaction, and, if carefully done with a sharp scissors, clipping will answer every purpose. Such hairs as are implicated in pustular formation can be epilated.

Besnier recommends complete epilation, followed by vapour douches, and continuous application of caoutchouc or rubber bound upon the lip, under which protection the irritation rapidly diminishes.

One of the most constantly praised applications in eczema of the upper lip is the Lassar paste, the composition of which is about as follows:

R. Zincii oxidi.	
Pulv. amyli	āā gram. 10.
Vaseline	gram. 20.
Acidi salicylici	centig. 0.40.

Dubreuilh omits the starch and adds about four grammes of sulphur, from which combination he reports good results.

If the eczema is of the seborrhoeal variety, attention must be paid to any existing pityriasis or seborrhoeal eczema of the scalp; for, as Unna has shown, unless the disease located here be kept in abeyance, recurrences will continue to take place on other regions.

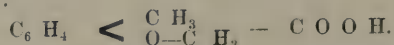
Enough has been said to show that there is no royal remedy, or even any general plan of treatment, for the cure of eczema, and as Besnier has well said: "He who will best treat eczema in general will be who will analyse with the most solicitude and attention the conditions presented by each patient, and will know how to rectify his hygiene and correct whatever may be faulty in his organs or their functions."

When this lesson has been learned, a great deal will have been accomplished toward a knowledge of how to cure eczema

A NEW DISINFECTANT SOAP.

The fact has been established that the heavy coal tar oils contain some ingredients other than carbolic acid which have a stronger bactericidal action than the latter and are much less poisonous. Crude carbolic acid, as it contains these strongest germicides, the cresols, would, therefore, be the best disinfectant but one—*i.e.*, corrosive sublimate—if it were soluble in water. As the cresols are, however, almost completely valueless in this insoluble condition, there has lately been put on the market a substance called Kresin, which is a disinfectant, antiseptic and deodorant of the greatest merit. It contains large quantities of cresol, the strong antiseptic and bactericide dissolved by means of sodium cresoloxylacetate, which has the same properties.

Kresin is a brown liquid smelling like cresol, entirely free from carbolic acid, and forming a clear solution on admixture with water. The chemical formula of this disinfectant is:



It has a number of advantages for use in surgery, &c., in comparison with the other antiseptic remedies, viz.:

As against carbolic acid: Is more energetic and trustworthy in action, less poisonous, and less caustic.

As against lysol, creolin, and sapocarbol: It does not render hands and instruments slippery; it is free from the pyridines and carbohydrates which are almost worthless for disinfection; it gives a clear solution with water, and it has a definite and unchangeable composition, its percentage of the active cresols being invariable.

As against the bichloride of mercury: Kresin does not injure metals; its action is not impaired by the presence of albumen in solutions; it is relatively very little poisonous, although of all the aromatic substances it approaches nearest to corrosive sublimate in its action.

From the foregoing it will be seen that Kresin is an ideal disinfectant and antiseptic for surgical use, as one per cent. solutions are sufficiently strong for purposes of asepsis, while even much weaker solutions neutralise disease germs and those products of decomposition which afford a ready nidus to germs in decaying animal and vegetable matter. From its small toxic power, Kresin may be employed, when sufficiently diluted, as a gargle, for inhalations and in the treatment of wounds generally. It destroys all contagious germs and foul smells, and kills mould, fungi, and dry-rot in houses. Mr. J. D. Stiefel, the well-known soap maker, of Offenbach, has succeeded in combining this disinfectant with soap in five and ten per cent. proportions.

This Kresin-Soap before and after surgical operations and in obstetric practice is highly praised by the few German specialists who have had opportunities of trying it. It is also found of great advantage in the treatment of certain eruptions of the skin, such as tetter, ringworm, lichen, and parasitic diseases.

In light cases patients should frequently wash the affected parts with the Soap, especially after dinner and before going to bed, with as warm water as can be comfortably used. In order to produce a stronger effect it is advisable not to wash off the lather but to rub it in the skin with a clean towel. To obtain the best action in special cases the affected parts should be washed before going to bed, and a thick lather allowed to remain upon the surface during the night.

These Soaps are sold at 8s. 6d. per dozen tablets. Single tablets may be obtained post free for ten stamps, from Mr. Stiefel's British Depot, at 46, Holborn Viaduct, London, E.C.

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

MIGRAINE may be relieved, Lucking says, with a pill, twice daily for some time, consisting of Indian hemp one-sixth grain, phosphide of zinc one-tenth grain, and arsenic one-thirtieth grain. The severity of the attack may be effectually diminished with liquor trinitrinæ in minim doses two or three times daily.

BROMIDISM may be prevented, says Dr. Fréré, by an intestinal antiseptic being combined with the bromide salt, as in the following:

R. Potassii bromid	...	...	...	...	3ss.
Beta naphthol ..	...	...	...	...	ʒj.
Sodii salicylat	...	...	...	...	ʒss.

for each dose, which is considered curative as well as preventive.

TURPENTINE in typhoid fever is coming more and more in favour with the newer generation, though with many older practitioners it has been the drug upon which the greatest reliance has been placed. Wood regards it as invaluable where, in convalescence, symptoms point to slowness of healing of the ulcers, or where, in the second week, there is decided typhinitis.

ECZEMA OF THE VULVA.—Lusch gives the following formula:

R. Tinct. opii.	...	...	...	...	āā gram 8.
Sod. bicarb.	...	...	...	...	gram 4.
Potass. bicarb.	...	...	...	...	gram 6.
Glycerin (neutral)	...	...	...	...	gram 260.
Aq. dest.	...	...	...	...	...

RESORCIN in chemically pure ten per cent. solution, applied to the peri-laryngeal mucous membrane by means of an applicator in form of a thick brush of fine hairs, is said by Moncorvo to abort an attack of pertussis in twenty-four hours, and cure the disease inside of two weeks. Applications are to be made every two or three hours. In severe cases antipyrin in daily quantity of from one to three grammes are given at the same time as well as inhalations of pyridine.—*Ann. de la Polic.*

PRURITUS IN URTICARIA is relieved by Prof. Quinquaud with the following solution:

R. Boric acid	...	...	...	...	30 parts.
Chloralhydrate	...	...	...	...	5 parts.
Distilled water	...	...	...	...	180 parts.

SMELLING-BOTTLE FOR COLD IN THE HEAD.—Dr. Tucker Wise has found the following highly satisfactory: Fill a wide-mouthed ounce bottle with coarsely pounded carbonate of

ammonia, and add eucalyptia, ʒss., dissolved in spirits of chloroform (double strength), ʒjss. This bottle should be applied to the nose as ordinary smelling-salts every half-hour, and the pocket-handkerchief be used gently when absolutely required, not violently trumpeting the nasal organ on every occasion that the passage becomes blocked. With the addition to this simple treatment a hot foot-bath may be taken, and steam inhalation at night.

IMPOTENCE.—Probably the most frequent, and at the same time the most intractable, cases which present themselves before a specialist in genito-urinary diseases are those of "sexual debility;" and this, again, is most commonly exhibited in the forms of sexual impotence and nocturnal emissions. Both forms are usually the result of excess, but it is no uncommon thing to find a married man, with no trace of previous pernicious history and of present temperate habits, complaining of oncoming sexual inability. These are of all cases the most unsatisfactory, owing to the serious mental depression which almost invariably accompanies them, and which occasionally culminates in suicidal mania. In all these cases much may be done by improving the patient's general condition, which is usually below par, by attention to hygienic surroundings, and by electropathic treatment. It is all important, however, that we should have the assistance of a really reliable drug, but up to the present our efforts to procure such have not been over successful. Lately, however, Messrs. Eli Lilly and Co., of Indianapolis, have introduced a pill composed of extract of damiana, in combination with phosphorus and nux vomica, which has produced, in my practice, more satisfactory results than I have obtained from other remedies.—GORDON G. JONES, L.R.C.P.Edin., L.F.P.S.Glas., Surgeon to Hospital for Urinary Diseases, Soho.

TREATMENT OF CROUP.—Dr. N. S. Davis says all the indications for treatment of croup, in the mild or superficial form of the disease, can be fulfilled by the administration of:—

R. Syr. ipecac ʒix.
Syr. scillæ comp. ʒiiss.
Tinc. opii camph. ʒij.
M. Sig.: Half teaspoonful every three or four hours.

EFFECTS OF ERGOT.—Dr. Meigs says: If an ergotic pain is produced to last thirty minutes, in a case where the placenta is on the fundus uteri, and to be jammed for thirty minutes against the child's breech, without an instant of relaxation, who can doubt that its circulation is either wholly or nearly abolished, and that when the child emerges at last from the mother's womb, it will emerge quite dead, or in a profound asphyxia from the long suppression of its placental circulation? Multitudes of children are born dead from this very cause, by the imprudent exhibition of a medicine which *certainly excites spasm of the womb as nux vomica does of the other muscles of the body.*—*Medical and Surgical Reporter*, Philadelphia.

Dr. Drapes says that in simple atony of the uterus ipecacuanha is a powerful agent in producing uterine contraction during the first and second stages of labour. In general two or three doses of from ten to fifteen drops of the wine of ipecacuanha, given at intervals of ten minutes, produce in a short time marked activity of uterine action and a rapid birth. It is much better than ergot, as it does not produce tetanic contraction, but only induces normal and regular expulsive efforts.

Dr. James Mitchell reports that Caulocorea is more agreeable to patients and more expeditious in action than ergot, after having several opportunities of administering it.

TETANUS TREATED BY COLD BATHS.—Dr. Rivière has observed two cases of tetanus with high temperature treated with cold baths. In each case chloral and opium had failed to give relief, and as the temperature was high it occurred to the author to try the effect of immersing the patients in cold baths. This was done with marked success, there being in one case no recurrence of trismus or rise of temperature, and convalescence taking place in about a week. In the other case the bath was repeated several times, always with good results, both as regards fall of temperature and disappearance of the spasms.—*Lyon Médical*.

BEEF JUICE.—Where it is necessary to give an invalid just the juice of beef, broil, say, a half pound for just a moment over a quick fire, then score it thoroughly, put it in a lemon squeezer, and press the juice into a cup, add a grain of salt, stand the cup in hot water for a moment until the juice is warm, and use it immediately. This is more tasty and appetising than beef tea.

The New Pseudonym. "A Study In Temptations," by John Oliver Hobbes.

Author of "Some Emotions and a Moral," "The Sinners Comedy,"
Ec., ready this day. Price 1s. 6d.

LONDON: T. FISHER UNWIN.

BACK NUMBERS OF MEDICAL REPRINTS.

The following issues are out of print:—

No. 1 (February, 1890).	No. 14 (March, 1891).
No. 7 (July, 1890).	No. 17 (June, 1891).
No. 10 (November, 1890).	No. 19 (August, 1891).
No. 13 (February, 1891).	No. 22 (November, 1891).

Any other back number will be sent post free to any medical man on receipt of three penny stamps.

[For contents of numbers dated earlier than January, 1893, see former issues of MEDICAL REPRINTS.]

No. 36 (January, 1893) contains:—

Therapeutic Value of Lactopeptine. By Edward A. Piggot, L.R.C.P. and S. Edin., &c.; Case of Anteversion. By H. Hobart Dorman, M.D. Dub., &c.; Excision of the Ossicula in Chronic Aural Catarrh; with instance of a failure. By H. V. Wurdemann, M.D. Diagnosis of Spinal Cord Lesions. By F. Peterson, M.D. (With Five illustrations.)—Case of Late Hereditary Syphilis, with Nasopharyngeal Lesions. By J. F. Klinedinst, M.D. (With an illustration.)—American Opinion.—News and Notes.—Continental Practice.—Therapeutic Notes.—Portrait: Sir Richard Owen.—Views: Sheen Lodge.—The Northern Hospital, Liverpool.—The New Psychiatriche Klinik, St. Petersburg.—Index, Frontispiece, and Title-page to Volume III.

No. 37 (February, 1893) contains:—

Were Protoplasmic Reversions checked by Alcohol? By Wm. H. Pearce, M.D. Edin., &c.; Early diagnoses of Mastoid Disease. By D. Milton Greene, M.D. (With an illustration.)—Diseases of the Frontal Sinus. By D. N. Rankin, A.M., M.D., &c.; Case of Ununited Fracture of the Femur. By W. Treacy, M.D.; Medical Literature.—I. A Book of the Month. Reviewed by J. E. Bullock, M.D. Brux, M.R.C.S. Eng., &c.; News and Notes.—American Opinion.—Therapeutic Notes.—Portrait: Dr. William M. Polk.

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IN BULK FOR DISPENSING, for the Medical Profession, price 12/6 per lb. Carriage extra. In 1-lb. and ½-lb. bottles. 1-lb., post free, 13/-; ½-lb., post free, 6/6. No samples.

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MR. RICHARDS is constantly asked for samples of his various preparations. Of some preparations no samples are issued; of others, Mr. Richards will always be glad to forward samples to medical men on application. For the convenience, therefore, of correspondents, he begs to append a table showing the names of the preparations in each class.

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I.—WHAT IT IS.

A vegetable alterative of unique value in the treatment of SYPHILIS—Secondary and Tertiary, Eczema rubrum, Psoriasis, Scrofula, Rheumatism, and other Diseases of a Syphilitic origin.

Each pint bottle of "SUCCUS ALTERANS" (McDADE) contains in natural combination the unimpaired virtues of sixteen troy ounces of the true medicinal plants, *stillingia sylvatica*, *smilacarsaparilla*, *phytolacca decandra*, *lappa minor*, and *zanthoxylum carolinianum*, collected in their native growth under the personal supervision of Dr. G. W. McDade, and manufactured while still in the green state, the compound being made in the same proportions as indicated in the original formula, published by Dr. J. MARION SIMS in the *British Medical Journal*, March 10, 1883, and endorsed by DR. B. RUSH-JONES, and many other eminent physicians. It is certified by DR. McDADE as a strictly trustworthy and uniform preparation, made only from green drugs collected in proper season, and is the only preparation from which the remarkable results obtained by DR. MARION SIMS and others can be relied upon.

II.—WHAT IT DOES.

The value of SUCCUS ALTERANS (McDADE) is attested by the following letters:—

Invariable Success.

I have used in my practice the preparation known as "Succus Alterans" (McDade), and have much pleasure in bearing testimony to its great value.

For diseases having their origin in a syphilitic source, I believe the "Succus" to be the one reliable specific, for I may add that invariable success has been met with by me when prescribing the remedy in question, even after the failure of all other alteratives.

I shall continue to rely on the "Succus" in all cases I have indicated herein.

WM. RD. GOODFELLOW, M.R.C.S., L.S.A.

Roche, Cornwall, March 20th, 1889.

Very Much Delighted.

I have been very much delighted with the action of Messrs. Eli Lilly's "Succus Alterans McDade."

In one case of specific disease of many years' standing, my patient had been obliged to take Pot. Iod. in large, depressing doses ever since the onset of the attack, and it really seemed that he would be doomed to a life of Iodide of Potassium. I gave him "Succus Alterans McDade," and in three months he was a different man; in six months he was practically cured, and he has been enabled to do without the Iodide ever since the commencement of the new treatment.

An alterative tonic its effect is simply splendid.

Yours faithfully,

J. STENSON HOOKER, L.R.C.P. and S.

Clive Vale, Hastings, April 10th, 1890.

Surprised at the Rapid Improvement of Patient.

With regard to the preparation of Succus Alterans, I have made a trial of it in two cases, in both of which I think it has been of service, but in the first one the purgative element seemed a little too pronounced, and I had to discontinue it for a time.

The second patient was suffering from syphilis of throat, mouth, and tongue, and had been under treatment at several Metropolitan hospitals, presumably with the usual anti-syphilitic remedies. This was a case of the later class of syphilitic manifestations, viz., those of a gummatous character. The lesions were severe and deep, and there were signs of the same disorder affecting the cerebrum. I must confess to be one of those who regard mercury alone as being of any real use in syphilis, and therefore I must say that I was somewhat surprised at the rapid improvement this patient made under 1 drachm-doses of the remedy. The fissure in the tongue began to close, and a nasty deep ulcer of the lower lip is almost well.

There is evidently some potent influence in the preparation, but in which of the remedies, or whether in the combination, I cannot say. The facts are as I have stated. Our arsenal of weapons against this horrid disorder is not over well filled, and you certainly have provided a remedy which does neutralise the poison of syphilis in some cases. It is only fair to tell you what I have found the medicine to do, and without indulging in a eulogy of it, I must say that under similar circumstances I should certainly try it again.

JOHN G. MARSHALL, B.A. CANTAB., M.B., M.R.C.S. ENG.

St. Margaret's Bay, near Dover, June 4th, 1890.

Much Good Effect.

I have prescribed your Succus Alterans in syphilis accompanied with obstinate skin affections with much good effect. It seems to raise the vital power so well in the depressing stage of the disease.

JAMES STARTIN, M.R.C.S. ENG., Senior Surgeon to the London Skin Hospital; Consulting Surgeon to the Sheffield Public Skin Hospital.

17, Sackville Street, Piccadilly, W.

III.—HOW OBTAINED.

To avoid complications it is desirable for medical men, in prescribing this remedy, to specify in full—R "Succus Alterans" McDade (Lilly's). It is sold in large amber glass bottles, containing a pint, at eleven shillings (never in bulk), and may be prescribed in original packages if desired. Price 11/- To the Medical Profession, 9/6; post free, 10/-. No samples.

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Formula.

R	Ext. Damiana	-	-	-	2 grs.
	Phosphorus	-	-	-	160 gr.
	Ext. Nux Vomica	-	-	-	1/8 gr.

Dose—

One to three pills, three times daily, with food.

Advantages.

As the DAMIANA used is the genuine TURNERA APHRODISIACA, this preparation can be relied upon. By our process for the manufacture of PHOSPHORUS PILLS, a thorough subdivision of phosphorus in the mass is obtained, and, with a coating perfectly PROTECTING it from OXIDATION, there is nothing further to be desired.

Uses.

Indicated in MENTAL OVERWORK, SEXUAL DEBILITY, IMPOTENCY. Decidedly beneficial in cases of NOCTURNAL EMISSIONS, the result of excess; in MENTAL APATHY or indifference, and in an ENFEEBLED CONDITION OF THE GENERAL SYSTEM, with WEAKNESS OR DULL PAIN IN THE LUMBOSACRAL REGION. Also act in the female as a UTERINE TONIC; hence, indicated in LEUCORRHOEA, AMENORRHOEA, DYSMENORRHOEA, and to remove the tendency to repeated miscarriage.

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See also the following:—

"I have found Pil Aphrodisiaca (Lilly), in cases of extreme exhaustion and mental apathy from overwork and continued anxiety, very beneficial in promoting a good appetite, refreshing sleep, and giving tone to the whole nervous system. In such cases I order one pill three times a day, for two days; I then give four pills during twenty-four hours. At the end of ten days the patient is taking eight pills in the twenty-four hours, and by this time is generally better. I remain, yours truly, "SPENCER S. DUNN, M.B. & C.M.

"Osbornville, King's Heath, "Birmingham, Sept. 5th, 1890."

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These Suppositories are encased in a covering impervious to moisture, unchangeable, and easily removed, preserving the Suppository in all climates. The Suppository causes no irritation of the rectum.

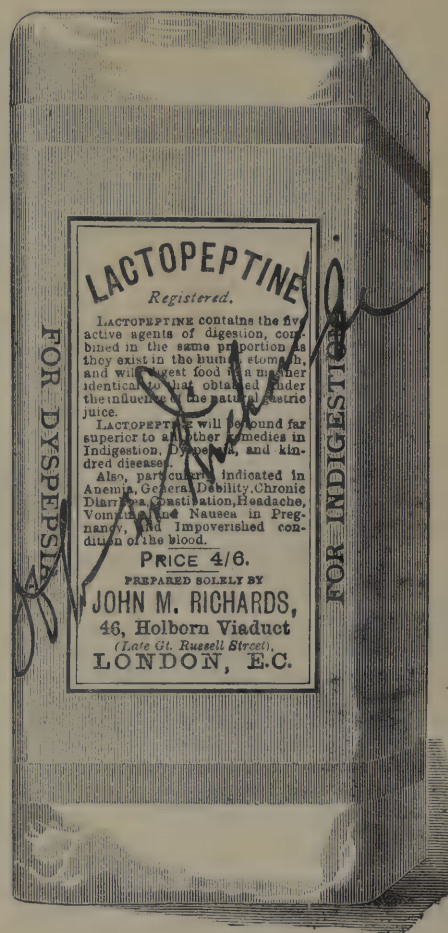
The value of GLYCERINE SUPPOSITORIES in Constipation is well established, painless and copious stools being promptly produced. The Glycerine acts by lubrication and solution of the indurated faeces, and by stimulating the bowel, thus providing a certain and agreeable method of emptying the colon at pleasure.

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MEDICAL REPRINTS

Home, Foreign, and Colonial: with Original Essays.

VOL. IV.]

LONDON: APRIL 15TH, 1893.

[No. 39.]

CYLINDROIDS OR SO-CALLED MUCOUS CASTS.

[Read before the Section in Genito-urinary Surgery of the New York Academy of Medicine, December 8th, 1892.]

By MORRIS MANGES, A.M., M.D., Physician to Outdoor Department, Mount Sinai Hospital, New York.

ALTHOUGH earlier writers had not infrequently called attention to bodies in the urine whose form resembled that of renal casts, yet it was not till 1870 that Thomas (1), while observing the urine in scarlet fever, carefully studied the forms to which he gave the name of cylindroids. This name he applied not alone on account of their resemblance to true casts, but because they so frequently occurred with the latter, and also reacted in a similar manner toward acetic acid. Kovida (2) carefully analysed them chemically and showed the identity of their composition with that of renal casts. They were mentioned by Bartels (3) and Wagner (4). Bizzozero (5), Eichhorst (6), Neubauer and Vogel (7), von Jaksch (8), Fürbringer (9), Leube (10), and Rosenstein (11) also described them. The most exhaustive study on this subject was made by von Török and Pollak (12) in a prize essay entitled "Ueber die Entstehung der homogenen Harncylinder und Cylindroide."

Most of these writers agree, in some measure at least, in recognising cylindroids as renal products bearing a more or less close resemblance to hyaline casts. Other authors regard them only as forms of mucin. Thus Baginsky (13) spoke of them as hyaline mucous shreds, which may be found in the urine of scarlet-fever patients. Tyson (14) states that occasionally casts may be found which are apparently "pure mucus-moulds of the uriniferous tubules. These forms, in his opinion, undoubtedly come from the kidney, and must be distinguished from the bands of mucin which are found in hyperacrid urines.

Millard (15), in his treatise on Bright's disease, in which he has so carefully and thoroughly distinguished the relations of mucin to albuminuria, speaks of mucous casts, but denies that they have any significance except that they are often mistaken for hyaline casts. The mucous cast, as distinguished from true casts, he maintains, is not an inflammatory product. Vierordt (16), while describing mucin, says: "Several forms are characteristic; among these are cylindroids, or microscopic shreds of mucus which careless observers may mistake for casts. Their origin and diagnostic significance are uncertain; they may be found (accompanying casts) in nephritis, in cystitis, and even in healthy individuals."

Peyer (17) also considers them products of mucus. He gives excellent plates (see Plates 6, 32, and 64) showing various varieties, including prostatic and spermatic cylinders. Saundby (18) coincides with the above views and simply speaks of them as mucous cylinders.

Von Hösslin (19), in 1889, described an unusual form of casts which he found in the urine of an epileptic after a very severe renal colic which lasted eighteen hours. The urine passed after the attack had a specific gravity of 1.035 and was laden with urates. With the naked eye numerous flakes could be seen floating in the urine. Under the microscope these were found to consist of sharply contoured hyaline casts, branching dichotomously, and between which were finely granular uratic deposits. As the urine was free from albumen, von Hösslin believed that these casts could not consist of any albuminoid substance. Inasmuch as mucin is increased in quantity in renal colic, he therefore asserted that in this case the secretion of mucin was so great that mucin casts were formed in the kidney. The fact that he could never find casts after any of the epileptic attacks which the patient subsequently had excluded the possibility of including them under his latter group.

In a paper on Tube Casts and their Diagnostic Value, read before this year's meeting of the Association of American Physicians, Danforth (20) divides these bodies (*i.e.*, casts) into two groups, of which one includes the ordinary forms, the other being the mucin casts. These, he states, are "the characteristic

morphologic products of catarrhal nephritis and establish its differential diagnosis."

Cylindroids have also been variously mentioned as prostatic cylinders or tubules, spermatic casts, etc. On the other hand, very many recognised standard text-books do not even mention them.¹

Description.—Cylindroids are ribbon-like forms, usually of great length and of about the same diameter as renal casts. They may assume various shapes, due to bends and twists which are usually in their longitudinal axis, giving them a corkscrew appearance. These axial twists are most frequently observed near the extremities. Folds and lateral indentations are very common. The diameter may be uniform or varying; the latter is by far more common. Hence, as a rule, the extremities are narrow and elongated, and often bifurcated. Subdivision into three or even four branches is by no means rare. They are frequently thicker at one end than at the other. Their outlines are delicate, although more highly refracting than hyaline casts. A very characteristic feature is the longitudinal situation of various grades of delicacy; these markings not alone assist us in finding them, but are also a very important diagnostic feature which distinguishes them from true cylinders.

They may occur isolated or in groups of two or three, or even in large snarls; the latter may often be detected by following up one extremity of the cylindroid (Fig. 1). Not infrequently a specimen is at once cast and cylindroid, as where one end of a cast terminates in a spiral, striated form (Fig. 2). I have observed both extremities assume this form. One example which I saw of this variety had a body like a granular cast (probably due to some extraneous precipitation); in still another example this granular appearance was present in two portions of the specimen, the intervening space being quite hyaline, while the extremities were typically cylindroidal (Fig. 3). Finally, cylindroids may occur inclosed in hyaline casts, as is well shown in Fig. 4.

Like true casts, cylindroids may bear various forms of epithelium, red and white blood-cells, crystals, detritus, fat-droplets, and bacteria. These may be inclosed within or may simply be adherent. When covered with amorphous deposits they may strongly resemble granular casts.

Their length is characteristic. According to Bizzozero (5) (*loc. cit.*, p 281), they may even be one millimetre long. It is common to see them extend over two, three, or even five fields of the microscope. The diameter of the thin forms (Bizzozero) is 1 to 2 μ ; the broader varieties measure between 5 and 10 μ . False cylindroids may be much broader than this.

Classification.—The classification of these bodies into two great groups—the true and false cylindroids—is of importance, not alone in estimating their diagnostic significance, but also in explaining the differences of opinions held by various writers on this subject. That some cylindroids are renal in origin is positively shown by the fact that von Török and Pollak (12) have actually seen them in the uriniferous tubules in sections of a large white kidney, of a waxy kidney, and numerous cases of chronic parenchymatous nephritis. Furthermore, they were also found in the kidneys of rabbits poisoned with cantharides and bichromate of potassium; in experimental stenosis of the renal veins; in ligation of the renal arteries; and also where the ureters were tied off (Fig. 5). Another very strong proof that cylindroids are formed in the kidneys is shown in the curious casts inclosing cylindroids (Fig. 4). As von Török and Pollak observe, unless we accept the view that the cylindroid already existed in the tubule where it was subsequently inclosed in a matle of albuminoid material, we must assume that the cylindroid forced its way into the already formed

¹ Da Co-ta's paper in the *American Journal of the Medical Sciences* for January, 1893, is an excellent proof of this assertion. Although very careful chemical and microscopical examinations of the urine were made in all his cases, yet cylindroids are never referred to. This is all the more striking since nowhere else do these bodies occur more frequently.

cast. For this, however, it is not rigid enough, as any pressure from behind would simply press the spirals of the cylindroid closer together. The alternation of casts and cylindroids, their occurrence in the same specimen, in which they both contain exactly the same varieties of epithelial cells, blood-cells, detritus, etc., the similarity of their reactions to various chemical reagents—all these attest the correctness of this view. Finally, I have also seen them in urine drawn with the catheter in cases where there was absolutely no indication of pyelitis and cystitis (Fig. 6).



FIG. 1.—Snarl of interlacing cylindroids. (Low power.) From Bizzozero.

On the other hand, it is just as certain that others are formed outside of the kidneys. They may be readily observed in the secretions of the prostate, Cowper's and Littre's glands, the bladder, vagina, uterus, and urethra. They may also be seen in the urine voided *post coitum*, or after a hard passage, or after what Keyes has termed "milking the prostate." If any of the above secretions be mingled with perfectly normal urine, cylindroids may then be observed in the specimen (Figs. 7, 8, and 9).

Renal cylindroids have been subdivided into three groups :

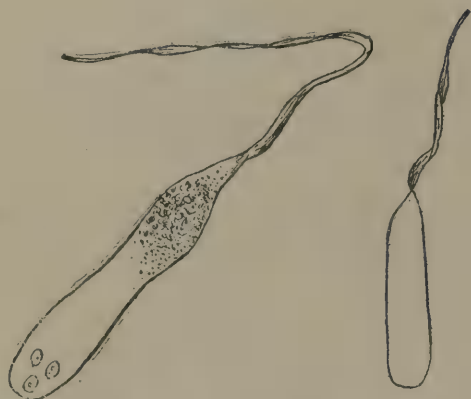


FIG. 2.—Combined casts and cylindroids. ($\times 400$.)

The specimen to the left was found in an acid urine (drawn by catheter) containing much free uric acid. The specific gravity was 1.030. Albumen and mucin were present in traces, with sugar 0.4 per cent. It contained three renal epithelial cells, and numerous small fat globules. Hyaline and fatty casts also were present. The other specimen also is from a gouty urine, very acid, of the specific gravity of 1.032, containing many crystals of uric acid and oxalate of calcium, together with hyaline and granular casts.



FIG. 3.—False cylindroid with deposit of amorphous urates. From a case of oxaluria; urine was very acid, specific gravity 1.028; contained urethral shreds, hyaline casts, and a small number of red and white blood-cells. A large trace of albumen and mucin also present. ($\times 400$.)

(a) small, narrow threads; (b) ribbon-like bodies; (c) collapsed tubules. Von Török and Pollak also mention another variety where the contours are very vague. This classification referring only to the shape has no practical significance.

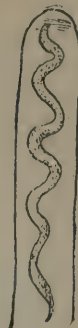


FIG. 4.—A hyaline cast containing a cylindroid. From a case of Bright's disease. (Von Török and Pollak.)



FIG. 5.—Sections of uriniferous tubules containing cylindroids. The specimen at the left was from the kidney of a rabbit in which the renal veins had been narrowed. The one at the right is from the kidney of a rabbit poisoned with cantharides. (Von Török and Pollak.)

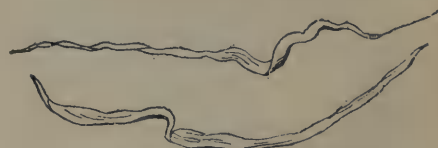
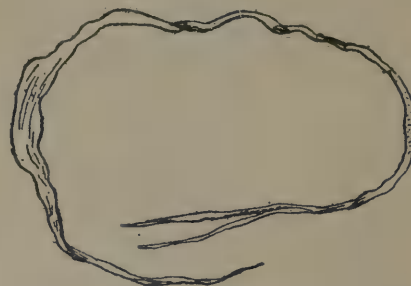


FIG. 6.—Renal cylindroids from a case of typhus fever. Urine contained small trace of albumen, red blood-cells, hyaline and epithelial casts. Cylindroids were soluble in acetic acid. A few adherent red blood-cells in one of the specimens. Urine was high-coloured, acid; specific gravity, 1.028. ($\times 400$.)

(To be continued.)

A GYNÆCOLOGICAL STUDY: ELIXIR CAULOCOREA AS AN UTERINE TONIC.

By EDWARD A. PIGGOTT, L.R.C.P. & S. Edin., L.S.A. Lond.
[An Original Article specially written for MEDICAL REPRINTS.]

It has long been a desideratum with gynæcologists to obtain a reliable drug, or combination of drugs, which might be safely classed as an uterine tonic; one which would exert a powerful influence over the pelvic organs, more especially the uterus and its appendages, not so much as a parturient after the manner of the ergot of rye, which, according to some authorities, acts by stimulating the centre for the uterus in the spinal cord, but by causing a contractile action upon the muscular fibres of the organ through the general blood supply. The action of ergot is always more or less uncertain, and in some cases of cardiac disease its exhibition might be attended with serious consequences; its chief use, therefore, would appear to be relegated to the domain of obstetric practice.

For some years a preparation which has received the name of "Elixir Caulocorea" has been prescribed with much success

by our professional *confrères* in the United States, and the testimony adduced by the numerous American practitioners who have resorted to its use, is certainly most encouraging.

The preparation is compounded from several drugs, the chief of which are as follows:—

Caulophyllum Thalictroides.

Viburnum } Opulus.

 } Prunifolium.

Aletris Farinosa—Spts. Etheris Comp.

The first of these drugs (*caulophyllum thalictroides*) owes its therapeutic value to an active resinoid substance—*caulophyllin*. It is employed as an uterine tonic, sedative, and anti-spasmodic, and it is especially useful in hysteria, amenorrhœa, dysmenorrhœa, and threatened abortion. (*U.S. Dispensatory*.)

The second drug employed, *viburnum prunifolium* (black haw), according to Dr. Phares, who first called attention to it, and who affirms it to be useful as a nervine tonic, anti-spasmodic, astringent, and diuretic, is particularly indicated in the nervous diseases of pregnancy and in the prevention of miscarriage. (*U.S. Dispensatory*.)

Its value seems to be well appraised by *The Provincial Medical Journal*, October 1st, 1891.

"It seems to be a carminative to the stomach and bowels, a sedative to the nervous system, and the best tonic we possess in its action upon the uterus and appendages. It is valuable in amenorrhœa and all forms of dysmenorrhœa."

The remaining drugs which enter into the composition of the elixir are each of them possessed of similar attributes, only in a less degree—the spts. ætheris comp. enhancing their action and acting, in addition, as a preservative of the preparation.

It will thus be seen that theoretically we possess an uterine tonic of exclusive value, and should theory be confirmed in practice, the gynecological physician will most assuredly be the gainer.

The therapeutic action of *caulocorea* may be briefly summed up as follows:—Emmenagogue, parturient (to a certain degree), antispasmodic, diuretic and tonic—the last-named action being by far its most important characteristic—in fact its other influences are undoubtedly subordinate to its action as a tonic. I have remarked above that, "theoretically," this preparation is, *par excellence*, an uterine tonic; it would, perhaps, be more correct to say in so far as is evinced by the results of practice in this country. American physicians appear long since to have arrived at a practical conclusion.

The drug may be employed with advantage under the following conditions, viz.:—

(a) In most cases of uterine atony, from whatever cause arising; more especially those following parturition, where the uterus remains enlarged, congested, and tender on the slightest pressure, a condition recognised under the general term sub-involution. This condition frequently follows parturition at full term, especially in twin pregnancies, or in those cases where the uterus has been preternaturally distended from an excessive amount of liquor amnii (*Hydramnios*).

(b) In displacements—*i.e.*, versions and flexions—which, in a large percentage of cases, are merely the result of sub-involution. These cases may often be satisfactorily treated by *caulocorea*, without resorting to the mechanical treatment by pessary, provided the patient be strictly enjoined to maintain the recumbent position.

(c) In irregularities of menstruation it is specially indicated:—

Amenorrhœa, dysmenorrhœa (congestive), menorrhagia, all derive more or less benefit from its powerful tonic action.

(d) Pelvic hæmatocele, or pelvic thrombus, after the subsidence of the more acute symptoms, and when absorption of the effused blood is taking place, is materially relieved.

(e) In threatened abortion *caulocorea* is stated to act with marked benefit, but in such cases I have no personal experience.

Having now fully discussed the various abnormal conditions in which this preparation may be of signal service, I will pass on to the consideration and clinical history of two interesting cases which have recently come under my care; in the first of which the drug was used with most beneficial results. The second case I report at length, for two reasons; firstly it is, *per se*, an instructive case; and, secondly, just such an one suited to the treatment by *caulocorea*. Unfortunately, at the time the case in question was under observation, the preparation had not been brought to my notice, or the patient would, I feel certain, have made a more rapid recovery.

Case I.—(Abridged report).

A. B.—; married woman, aged twenty-four years, with one child, had suffered from dysmenorrhœa since the birth of

infant; menstruation was normal in so far as regularity was concerned, but was always preceded for some days by severe pain in the head, with giddiness, and a feeling of lassitude. The menstrual flux was invariably arrested on the second day after its appearance, the suppression being accompanied by a sensation of weight and dragging in the pelvic region.

On January 31st, 1889, after attempting to lift a heavy weight, the patient was alarmed by experiencing a sudden loss of blood from the uterus, and at the same time was aware of a sensation, as of something "giving way." Most serious symptoms immediately supervened. The surface of the body became blanched and of a waxy hue; pulse accelerated (140 to 150); short hurried respiration, with sudden unconsciousness, rapidly passing into a complete state of collapse, all the indications of severe internal hæmorrhage being developed. The patient remained in this critical condition for some eight or ten hours, when reaction slowly commenced to set in.

The following day, February 1st, the pulse was 120 to 130 with a gradual return of consciousness, retention of urine, which was relieved by means of the catheter, the bowels requiring to be moved by the injection of glycerine. The case proved one necessitating long and careful treatment. After eight to ten weeks' confinement to bed the patient was gradually allowed more liberty, but it was at least three months from the time of attack before she could safely be pronounced convalescent. Since this severe illness the patient has passed through a normal pregnancy and given birth to a second child. She still suffers from dysmenorrhœa with the dragging sensation in the pelvic region. For this I have lately prescribed elixir *caulocorea* with marked relief to those distressing symptoms; in fact, she states that she has derived greater benefit from the prescription than from any other medicine that has been prescribed.

The case was diagnosed as one of pelvic hæmatocele; to describe it in detail would occupy more space than is allotted to me.

Case II., M. O.—; aged thirty-five years, wife of an agricultural labourer, sought advice about the termination of the eighth month of pregnancy. She complained of severe pain in the right side, and had suffered from vomiting for two or three days. The patient was naturally a healthy-looking woman.

Upon visiting her on June 27th, 1892, her appearance seemed very much altered, her features bore an anxious expression, and were much sharpened, the eyes being sunken, with an absence of their usual lustre; the skin, especially of the face, was of a cadaverous hue. There was much embarrassment of respiration owing to the pressure exercised upon the diaphragm by the uterine tumour. Pulse 100, weak; legs cedematous, so much so that the contour of both limbs was obliterated. The abdomen was enormously distended, and the uterine tumour extended to the ensiform cartilage; it was of an uniform shape and dull on percussion, the superficial veins were much dilated, and more or less tortuous. Upon practising palpation the fluctuating wave of fluid was obvious, but no fetal limbs or movements could be detected. Auscultation gave a negative result, the foetal heart was inaudible. On making a vaginal examination the os was found dilated to about the diameter of a florin, and the tense membranous sac was easily made out. The presentation could not be diagnosed.

There had thus far been no actual signs of impending labour, and as there appeared to be no imminent risk to the patient I determined to temporise, merely prescribing an anti-spasmodic to relieve flatulence, with a dose of castor oil, as the bowels were somewhat obstinate.

At 10 p.m. on the night of June 27, some twelve hours after leaving the patient I was summoned urgently to see her. On arrival I was informed by the midwife that the patient's bowels were well relieved at 8 p.m., and after she had returned to bed at 8.45 p.m. the membranes ruptured spontaneously, when there was an enormous gush of water, the bed being deluged; the amount of fluid was so great that it streamed over the floor of the room. At a rough estimate I should say that there was at least three gallons of liquor amnii—the midwife estimating the quantity at a "pailful." The child quickly followed. The presentation, footling—still-born—about eight months' maturity. On seeing the patient at 11 o'clock p.m., I found the uterus somewhat flaccid, the placenta still retained within its cavity; it was, together with several large clots, expelled upon expression. The woman suffered considerably from shock; the pulse at 11.45 was 140, very weak. Some brandy and egg mixture was administered, and small doses of tincture of opium added to the anti-spasmodic mixture already prescribed. A binder was carefully adjusted above the hips. June 28th,

noon.—Patient expressed herself as feeling very comfortable ; has had two hours' good sleep ; œdema of legs much decreased ; skin moist ; tongue clean ; pulse 122 ; all difficulty of breathing disappeared. June 29th.—Condition remains favourable ; œdema entirely disappeared from lower extremities ; bowels well relieved ; pulse 96 ; temp. 99.4°. July 1st.—Pulse 118, weak ; temp. 101.2° ; breasts hard and painful. Belladonna ointment ordered to be applied, to relieve pain and diminish the secretion of milk. July 2nd, 8 p.m.—Pulse 112, stronger ; temp. 99°. July 12th.—Patient convalescent ; remains weak, but gradually regaining strength and appetite ; pulse 100.

Remarks:—

It would appear that cases of hydramnios are far from uncommon in midwifery practice, some authorities limiting the term to those in which more than two quarts of amniotic fluid exist.¹ Such cases, where the amount of fluid is not excessive, rarely give much trouble or inconvenience, either to the patient or her medical attendant, beyond prolonging the first stage of labour. The case I have under consideration is one of a very different type ; the uterus was distended to such an enormous extent that it virtually occupied the whole of the abdominal cavity, to the detriment of all the other important organs located therein, together with those of the thorax. The œdema of the lower extremities was proof positive of most severe pressure upon the iliac veins ; the circulation through those of the pelvis generally, and more particularly of the portal system, must have been greatly impeded. The patient's condition as to general constitutional disturbance was nearly approaching that observed in cases of ovarian dropsy, and had not the natural powers effected delivery, art must have been employed for the purpose of saving life. I may state that it was the patient's seventh pregnancy, and that she had on one occasion miscarried.

In conclusion I would remark that, although up to the present time the data gleaned from the results of British practice are insufficient to pronounce a conclusive verdict in its favour, the preparation (elixir Caulocorea) is certainly worthy of an extended trial.

SOME PHYSIOLOGICAL EXPERIMENTS WITH MAGNETS AT THE EDISON LABORATORY.

By FREDERICK PETERSON, M.D., Chief of Clinic, Nervous Department, Vanderbilt Clinic, College of Physicians and Surgeons, New York ; and A. E. KENNELLY, Chief Electrician, Edison Laboratory, Orange, N.J., Vice-President American Institute of Electrical Engineers.

[Read before the American Electro-Therapeutic Association, October 5, 1892, and before the Section in Neurology of the New York Academy of Medicine, October 14, 1892.]

MAGNETO-THERAPY has not gained such widespread application as has electricity in medicine, nor has it won to any great extent the confidence of the medical profession, for its effects are even more occult and less easily demonstrable than, for instance, the trophic influences of galvanism in poliomyelitis and progressive muscular atrophy. At the same time, magneto-therapy has its adherents and earnest promulgators, to which anyone will bear witness who has observed the transfer of singultus by a magnet from one girl to another in Charcot's dramatic realms at the Salpêtrière, or who has at the Poliklinik watched Benedikt carefully adjust a one-foot horseshoe magnet to the hyperæsthetic spine of a hysterical girl. There are many lesser men than these who have implicit faith in that mysterious force, and there is no dearth of theories to explain the effects of magnetism upon the human organism. Professor Benedikt has taught that erethetic forms of hysteria are better treated by the magnet than by electricity, hydro-therapy, or drugs. A magnet being applied to the sensitive vertebrae, without removal of the dress, the irritable patient soon becomes quiet and even quasi-paralysed. The magnet, therefore, "increases the resistance to conduction in the motor nerves." The muscles gradually relax, the respiration becomes sighing, consciousness slowly disappears ; the resistance to conduction in motor nerves "could easily become absolute." The two poles have different effects. Sometimes one pole to a hyperæsthetic ovary fails to relieve pain, whereas a change of the poles causes its speedy disappearance. According to him the magnet must be employed with due caution, since patients may be injured by it.

The status of magneto-therapy in America may be inferred from some quotations from the third edition of Robert

Bartholow's *Medical Electricity*, 1887. Under the heading of "Physiological Effects of Magnetical Applications" he says : "We know that a current circulates in a magnet. If a powerful horseshoe magnet is brought near to the skin, opposite electricities are attracted to the poles and currents are induced. About the point of application, therefore, the skin will be acted on directly by the magnetic current and by an induced current. The production of physiological effects, which can be recognised, is therefore merely a question of the magnetic strength."

He then quotes Dr. Vansant as assuming the body to be diamagnetic : "By applying north and south polarity to different parts, very extensive subjective impressions are experienced ; they are of two classes—of heightened organic activity, and the opposite condition."

He then adds : "That impressions of a very decided kind are produced by the application of strong magnets is evident in the experience of Dr. Proust and Dr. Ballet, who continued a course of investigation begun by Charcot at Salpêtrière." They ascertained that magnets could not be applied with impunity, for, if applications were prolonged, pains were felt in the epigastrium and thorax, making respiration painful, digestion was disordered, and boulimia brought on. These results were so uniform that there seemed to be no doubt of their genuineness in the minds of the investigators.

Under the heading "Therapeutical Application of Magnet," Dr. Bartholow quotes Dr. Hammond as preferring a horseshoe magnet, and advising that several of the same size be kept, so that by clamping them together more power can be obtained. The author adds : "Hammond insists on the necessity for the application of both poles in many cases, and therefore uses the horseshoe magnet."

"Hammond has used magnets in nine cases of chorea, in two complete cures being produced in a few minutes."

"In two cases of hemiplegia with hemianæsthesia Hammond had very surprising results from the application of horseshoe magnets, the sensibility returning immediately, and in one the hemiplegia was recovered from in a few hours."

The magnets used by physicians are generally those of a horseshoe shape, varying from a few inches to a foot in length, and are the so-called permanent magnets. They exert a traction force equivalent to several ounces, and sometimes to from one to three or four pounds.

Electro-magnets can be made to sustain two hundred pounds to each square inch, or fourteen kilogrammes to the square centimetre of active surface on either pole—that is to say, twenty-eight kilogrammes to the square of active surface on either pole if both poles are alike and share the load.

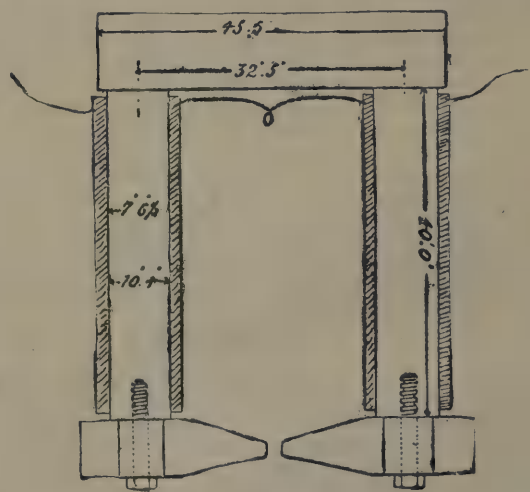


FIG. 1.—Plane section of magnet through core axes. Not drawn to scale.

While rather sceptical as to the practical utility of the magnet in medicine, it occurred to us that if there was any truth whatever in the claims made by various distinguished authorities, if this interesting and undoubtedly powerful force had any effect at all upon living organic matter, we were in a position to demonstrate its physiological effects by means of magnets of enormous power placed at our disposal at the Edison Laboratory at Orange, N.J., through the kindness of Mr. Edison. Accordingly we made experiments which we detail below, and which we consider as conclusive, in that they have been made with magnets of a strength possibly never before used for such purposes. The description of the

¹ Vide "On the Diagnosis of Dropsy of the Amnion." Kidd. Proceedings of the Obstetrical Society of Dublin, May 11th, 1878.

magnet employed for preliminary experiments is as follows (Fig. 1):

It is of wrought iron throughout, and its principal dimensions are represented in the sketch in centimètres. Roughly speaking, it is about a foot and a half wide by two feet long, and requires two men to lift it. The cross-section of the core is forty-nine square centimètres. The vertical angle of the cones is 36° , and the diameter of their plane faces 0.75 ctm. There are 2,728 turns of wire on each limb, making 5,456 in all, and the current employed in exciting it was approximately 4.5 ampères. The pole faces were 1.20 ctm. apart, and it was between them that objects were placed for observation either with the naked eye or with the microscope. The intensity of the magnetic field between these poles was about 5,000 C.G.S. lines to the square centimètre.¹

A drop of water placed on a glass slide in this field was visibly distorted in shape by the magnetic force.

The stage of the microscope was removed and wooden supports substituted. It was necessary to clamp the microscope down to the table to prevent its being drawn upward to the poles.

Nothing peculiar was noted in the effect upon iron in its finest powdered form, iron by hydrogen. It behaved just as iron filings would do, being strongly attracted. Iron by hydrogen placed in water was observed to be polarised by any ordinary magnet under the microscope.

Dry powdered hæmoglobin exposed to the strong magnetic field above described was not visibly affected by it. The proportion of iron it contains, however, is exceedingly minute (0.42 per cent).

It was then thought possible that the iron in loose combination with fresh hæmoglobin in the blood-corpuscles might be affected. Several experiments were made with both human and frog's blood. The blood, placed on slides and covered with a cover-glass, was subjected to the strongest magnetic influence obtainable, and failed to show the feeblest traces of polarisation, movement, or vibration.

It must be borne in mind that we were using an electro-magnet which we magnetised and demagnetised at will. First one would make the observations, the other experimenter

¹ C.G.S., or "centimètre-gramme-second," is the unit of measurement employed. The earth's magnetic field, measured horizontally for instance, is estimated to be 0.18 C.G.S. line to the square centimètre near New York. Consequently our magnetic field was 27,778 times that of the earth's horizontal component, that aligns the compass needle.

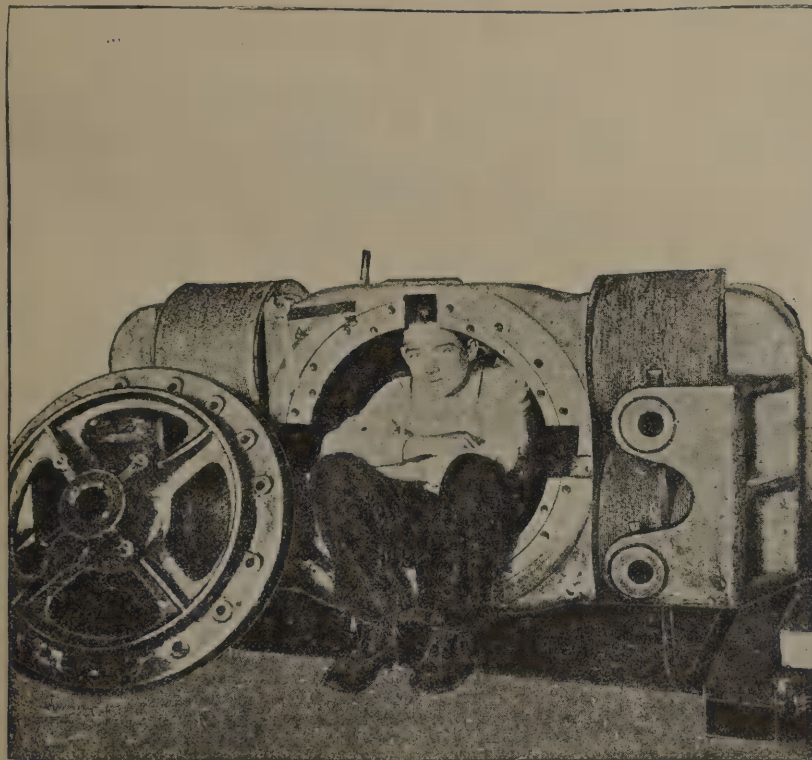


FIG. 2.—Showing field magnets in whose cylindrical cavity a dog was placed. The powerful attraction of bolts and chains is distinctly noticeable. The circular brass cover or door of the cavity is shown at the side.

attending to the current; then they were repeated and verified by the other on our changing places.

Living ciliated epithelium from the pharynx of a frog was now in like manner subjected to the magnet, and its behaviour watched under the microscope with a high-power objective, as the poles were magnetised and demagnetised by the making and breaking of the 120-volt current in the huge coils. The magnet had absolutely no effect upon the delicate ciliary movement which kept on continuously, nor did it cause the slightest change or vibration in the cells themselves, suspended in the saline solution. After the magnetic observation, a mild continuous electric current of one to two milliamperes C.S. was carried through the microscopic field containing the moving ciliated cells, and this also had no effect whatever upon the movement.

Another frog was now taken and curarised, fastened upon a pasteboard frog-plate, and the web of the foot stretched in the usual manner to show the circulation of the blood in the capillaries under high power. As before, the object to be observed was placed between the poles of our magnet and the microscope focussed upon it. The poles had to be separated somewhat farther to admit the large foot of the frog. With the clearance thus employed to allow of inserting the frog's foot, the magnetic intensity was reduced from 5,000 C.G.S. lines to the square centimètre to 1,500 C.G.S. lines to the square centimètre. Repeated observations by both of us failed to demonstrate the feeblest influence of the magnet upon the blood-cells or their movements in the vessels. At this point we determined to note the effect of the continuous current upon the circulation. A fine copper wire was placed upon one toe and another wrapped in moistened filtering paper above the ankle. The current strength in these trials never exceeded two milliamperes, and generally varied between one and two milliamperes.

Whenever the current was made the circulation in the foot under the microscope, which was about midway between the two electrodes (three centimètres apart), gradually grew sluggish and finally ceased, complete stasis being produced, the blood-vessels dilating. As soon as the current was cut off, gradually movement made itself manifest in the stagnant capillaries, and, becoming more and more lively, the circulation was in a few moments restored to its normal state. The effect was not due to the magnet, however, for it was observed with the current in the coils made or broken. This experiment was gone over frequently by each of us, so that the facts were fully verified.

It was now resolved to put Benedikt's statement to proof that magnetism "increases the resistance to conduction in motor nerves," thus causing paralysis. For this purpose a set of idle field magnets (Fig. 2) which converge into a cylinder two feet in diameter and seven inches deep was employed. In this cylinder a small and lively young dog was placed and kept for five hours, and subjected during all that time to the influence of a magnetic field whose intensity was from 1,000 to 2,000 C.G.S. lines to the square centimètre. Fig. 2 is taken with a boy inside of the cavity, in which the dog was kept for five hours. The magnets were excited while the photograph was being taken with the boy in it, as is evidenced by the position of the bolt above, and by the bar of iron, A B, which not only supports its own weight in this horizontal position when touching the pole-piece, but also supports the wrench at its outer extremity. The chain, too, is magnetically influenced. There was no effect upon the boy. A clearer idea of the power of this magnet may be obtained when I say that heavy bolts, chisels, and pieces of iron in the immediate neighbourhood of this cylinder were drawn to it irresistibly, and that it required considerable muscular exertion to remove them. A heavy bolt placed slightly above the centre or axis of the cylinder remained suspended for a moment in the air, like Mohammed's coffin, so powerful were the opposing magnetic forces upon it compared with gravitation.

The five hours' exposure to this influence had not the slightest visible effect upon the animal, which was rather livelier in its capers on being set free than before, owing to its joy at being liberated from the cage.

Our next experiments were directed to studying the influence of magnetic fields on the human brain. The type of dynamo employed for this purpose will be seen in the illustration (Fig. 3). The machine converts about 70 h.p. at full load. The armature and one journal were removed, leaving the space between the pole-pieces free. This will be best understood by reference to the figures. Fig. 4 gives a view of the pole-pieces into the cavity between which the head was to be inserted. This cavity is 35 centimètres (fourteen inches) in diameter, and 60 centimètres deep. The weight of this electro-magnet is over 5,000 pounds, and the intensity of the magnetic field produced within the polar cavity after removal of the armature, though not uniform, may be estimated at a mean of 2,500 C.G.S. lines to the square centimètre. A long board was placed upon the base plate leading into this polar cavity, and the subject experimented upon lay on his back upon the board with his head and shoulders in the cavity between the poles, and exposed thus to the full influence of the magnetic field. There would be comparatively feeble residual magnetism with no current in the coils. A switch so nearly silent in action as to be inaudible to the subject was arranged to close and open the exciting current circuit through the field coils. On closing the switch nearly the full magnetic intensity would be active and permeating the head within practically one second (theoretically it takes an indefinitely long time to establish the full current and magnetism). Similarly on opening the switch, almost the whole intensity would disappear in about one second.

Five men, ourselves among the number, were subjected to trial. One case described will describe all.

The subject lay back upon the board and concentrated his attention upon his sensations. His right wrist was extended and was grasped by one observer, who took sphygmographic tracings of the pulse. A second observer placed a hand on his chest to observe any irregularity that might occur in respiration. A third observer, in view of these two but unseen by the subject of the experiment, opened and closed the switch that excited and relaxed the field, signalling to the first two observers as he did so. The strong magnetic influence was therefore turned on or off at will and without the knowledge of the subject. Several sphygmographic tracings were taken in each of our subjects, and in one the knee-jerk was tested continuously.

The sphygmographic tracings taken continuously during the *séance* show no change in regularity, in spite of the making and breaking of the enormous magnetic influence during its registration. The respirations were not changed in the least. The knee-jerk also presented absolutely no change. As to common sensations, there were none that could be attributed to the magnetic influence, and the subject could not discover when or whether the field had been excited. The testimony of all five subjects was alike. In one experiment the subject held a steel screw in his mouth, and was then able to tell when the

poles were magnetised or demagnetised, but only by the pulling of the screw to one side or another, not by any peculiar sensation or taste.

Our last series of experiments was in connection with reversed magnetism.

A large coil of stout, cotton-covered copper wire, about 30 ctm. high and 25 ctm. internal diameter, composed of nearly 2,000 turns and weighing about 70 kilogrammes, was supported horizontally in such a manner that the head of the subject experimented upon could be freely introduced within the coil, and subjected to the electro-magnetic field created there by passing a current through the wire. The resistance of the coil was 10 ohms, and its inductance 0.73 henry. An alternating electro-motive force of 1,200 volts, making 140 cycles or 280 alternations to the second, was connected with this coil, the current supplied being 1.85 ampères. The magnetic field in the coil would thus be reversed 280 times to the second. Each of the authors acted as subjects in the experiments, permitting the 1,200-volt alternating current to be made and broken frequently in the huge magnetic coil surrounding his head. No effect whatever was experienced. The coil itself hummed with the current, and a strip of sheet iron held in the cavity of the coil, but not touching it, vibrated perceptibly in the hand and gave a distinct, loud sound, which was determined to be middle C of the musical scale by means of Helmholtz resonators.

The authors conclude that the human organism is in no wise appreciably affected by the most powerful magnets known to modern science; that neither direct nor reversed magnetism exerts any perceptible influence upon the iron contained in the blood, upon the circulation, upon ciliary or protoplasmic movements, upon sensory or motor nerves, or upon the brain.

While our observations with reversed magnetism indicate that no appreciable influence is exerted upon the brain when subjected to 280 magnetic reversals to the second, we were unable to experimentally alter this frequency, and the possibility remains that some particular frequency or frequencies might affect the nervous system. We hope to decide this question, within a suitable range of frequency, at some future time.

The ordinary magnets used in medicine have a purely suggestive or psychic effect, and would in all probability be quite as useful if made of wood.

While we have demonstrated conclusively the above facts, we do not deny the possibility of there being invented some-day magnets enormously more powerful than any yet known to us, which may produce effects upon the nervous system perceptible to some of the sensory organs; for magnetism is certainly a remarkable force, and we find it very difficult to understand why it seems to have no influence whatever upon the human body and its wonderfully delicate neuro-electric mechanism.

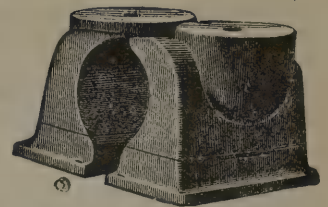


FIG. 4.—Showing merely the pole pieces of the dynamo, with the armature removed. The head was placed in the cavity between them.

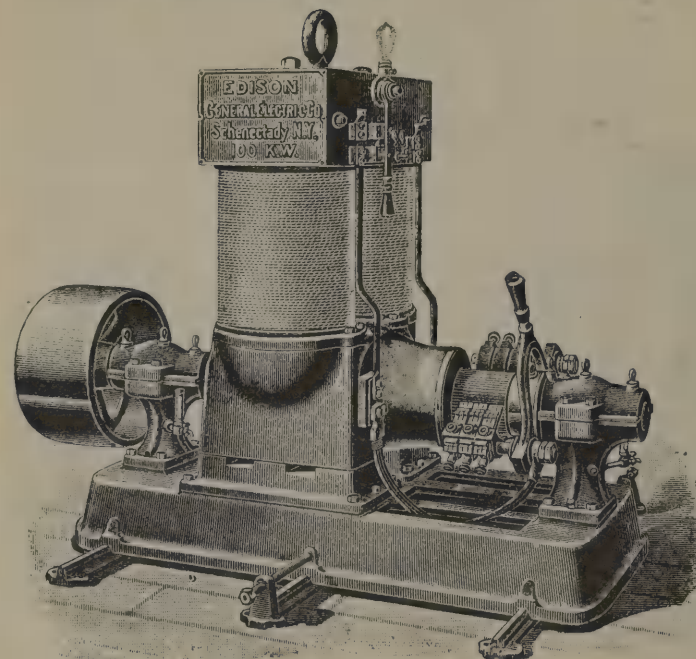


FIG. 3.—Type of dynamo used in experiments on the human head. The armature is in place.

THE RELATIONSHIP OF RHEUMATIC FEVER, HEART DISEASE, AND CHOREA.

By WILLIAM DOWNING, L.R.C.P. London; M.R.C.S. England.
[An Original Article specially written for MEDICAL REPRINTS.]

THE connecting link existing between rheumatic fever, heart disease, and chorea is probably due to some condition of the blood, which becomes a source of irritation to the various delicate tissues in its passage through the vessels. The lining membrane of the joints, the endocardium, or the basal ganglia, becoming congested, the continued circulation of the irritative fluid aggravates the mischief. A child, the possessor of a delicate nervous system, and predisposed by a disordered condition of the blood to chorea, may, by a sudden shock, become fairly launched in the disease; whilst the continuance of symptoms is maintained by the irritating effect of the blood at the affected centre. The beneficial effect of rest and sleep in chorea may be ascribed to the moderate amount of blood passing through the affected area. Anything calculated to remove the irritation from the system would, however, be the great desideratum, as a lessened circulation only leads to a partial removal of the irritating influence.

Salicylate of soda has been found almost a specific in

rheumatic fever, probably acting by modifying the condition of the blood. The relationship of rheumatic fever, heart disease, and chorea leads to the idea that the drug might prove of service in the latter complaints. Of course, to be of service in heart affections, it would be necessary to use the remedy in the initial stage; in acute endocarditis, however, the allaying of irritation would be invaluable, and damage which would otherwise result might in some cases be prevented.

In chorea, salicylate of soda may also be employed with the same object in view. In a recent case, after using the ordinary remedies, arsenic, etc., without effect, the complaint rapidly subsided with the use of salicylate of soda, in 6 gr. doses every four hours. The patient, who had no history of rheumatism, was a girl of thirteen, who practically recovered after a fortnight's use of the drug.

BOOKS.

[Works for notice under this heading should be addressed to the Editor at 46, Holborn Viaduct, not later than the 8th of the month. Publishers will assist the Editor and reviewers by stating the price of every publication forwarded.]

THE volumes called "Somnia Medici," First, Second, and Third Series respectively (London: Kegan Paul, Trench, Trübner and Co., 3s. 6d. each volume), if they do not contain anything that can be called poetry of the highest order, yet embrace much pleasing and some very powerful composition in verse, the work of Dr. J. A. Goodchild, a medical practitioner now resident in Italy. A strong individuality of style and treatment, marked by a singular absence of "echoes" from more prominent writers, may be, perhaps, the most notable of Dr. Goodchild's claims to celebrity. He is a follower of no school, and his Muse is singularly free from mannerism and affectation. The narrative poems are the strongest part of his work. It would be difficult, without copious quotation, to give an idea of their manner, which may perhaps be more readily suggested by saying that they are like the few similar pieces among the poems of Philip Bourke Marston, who, however, was not at his best in narrative verse. Dr. Goodchild is not the equal of Marston, except in this speciality; but he does less than justice to a facile, sane, and not ungraceful muse when he describes himself in a preface as "content to pour my dribble of weak wine into the flood of contemporary English verse as an addition to the bulk rather than to the bouquet of the whole."

The medical experience of the author shows itself here and there. The finely scornful sonnet "Antivivisection," beginning—

"Wailings of silly women, led astray
By full-fed ignorance, a sentiment
Fostered of falsehood"

—is perhaps better as argument than as poetry; but then "Myrrha," in the second series, is better as poetry than argument, is perhaps thought to redress the balance. "During Her Majesty's Pleasure"—a lurid and finely imaginative study in insanity, is perhaps the strongest piece in the volumes; but the Heine-esque "Lines on a French Picture," in the first series, are very beautiful, and the "Organ Builder" poem, in the second series, has a lingering charm which is quite its own.

The efforts of Miss Kate Marsden, F.G.S., a Member of the Royal British Nurses' Association and of the Russian Red Cross Society, on behalf of the Siberian Lepers, are already the subject of an honourable celebrity, and her work on the subject ("On Sledge and Horseback to Outcast Siberian Lepers." London: Record Press, 6s.), is but one stage of her untiring labours for the good of a community which one is almost tempted to think deserted by God and man. Miss Marsden takes occasion to say a good word for Russia and the Russians, in contradiction of contrary opinions very widely current. We are told to "bear in mind that there are numbers of noble men and women in the country always ready to stretch out the hand of fellowship to anyone coming in the Master's name to help His sick and suffering ones." The warning is illustrative of the author's attitude to all, and the beautiful charity of the lines just quoted pervades the whole book. For Russia and its rulers all Miss Marsden's charity must have been required when she witnessed the scenes which she describes with unflinching detail in her account of life in the leper colonies. The work contains a feasible scheme for rendering, we will not say, tolerable, but at least less intolerable the life of the wretched lepers, and it is to obtain funds for this most worthy purpose that the book is written. It is a deeply interesting volume,

the reward of noble and most self-sacrificing labour, bravely and unflinchingly undertaken, and the pioneer of an effort worthy of all honour and support at the hands of the medical and general public.

WE have received from America the first number of the *Woman's Medical Journal*, a monthly of fourteen pages of reading matter, "devoted to the interests of women physicians." E. M. Roys-Gavitt, M.D., is the editor-in-chief, Claudia Q. Murphy the managing editor, and Margaret L. Hackdorn the business manager. The salutatory editorial opens as follows: "There is an early Christian legend that says that when one of the saints applied for a home in a monastery the prior refused him entrance, on the plea that the monastery was already filled and there was no room for another novice. Undeterred by this announcement, the pilgrim took a glass of water which was well filled and in reply placed a rose leaf in it without spilling a drop. It is needless to say he was admitted. This story is not without its moral. They may say, and say truly, that the field of medical journalism is well filled, and that there is no room for another journal. We beg to present ourselves, even as the pilgrim to the monastery, with a rose leaf in our hands." We have heard this story told somewhat differently—a candidate for admission into the French Academy was shown a cup of tea full to the brim, but not a word was spoken; taking the act to imply that there was no more possibility of the number of the Immortals being increased than there was of his adding more tea to the cup without making it run over, the candidate laid a tea leaf on the liquid and gained his point. Whichever may be the original version, if either, and whether the ladies having this new journal to conduct come before the profession with tea leaves or with rose leaves in their hands, we welcome them to the editorial ranks. The journal is published in Ohio.

AMERICAN OPINION.

OTOSCLERONECTOMY IN CHRONIC AURAL CATARRH.


[From the "Medical News."]

OTOSCLERONECTOMY (*ὄψις, ὠτός*, ear, *σκληρός*, hard, *ἐκτομή*, excision) is a [word of] new coinage designed to express the surgical removal of a part or all of the sclerosed and ankylosed conductors of sound in chronic catarrhal otitis media. As this operation has for its object the relief of tinnitus, deafness, and aural vertigo, more interest surrounds it than environs otonecrotomy, or the excision and removal of the necrotic conductors of sound in chronic purulent otitis media. This interest is due to the fact that there are more cases of chronic catarrhal deafness than of chronic purulent otitis media seeking relief, and also because otonecrotomy is but following out an ordinary surgical indication, and requires no discussion. Though the earliest attempts at otoscleronectomy were made in Europe, the elaboration and signally good results of this operation are due to the acumen, industry, and boldness of American aurists displayed within the past decade. The great advance in aural surgery is the direct outcome of the enthusiastic and patient labour of a few men devoted solely to otology, untrammelled by any other special work. The pioneer work in the field of surgery performed by Sexton, of New York, and Burnett, of Philadelphia, has led naturally to the recent modified operation of Jack, of Boston—viz., the removal of the stapes only. These operations have proved beyond all cavil that the sound-conductors—namely, the membrana tympani and the three ossicles, can be removed, not only without any bad results to the patient, but with benefit to all the symptoms of chronic aural catarrh. Judging by past experience, the relief to deafness, tinnitus aurium, and aural vertigo is permanent, with the exception, perhaps, of a very small number of cases in which the indications were obscure—an incident common to all surgical procedures.

From the experiments of Sir Astley Cooper down, it has been observed that, generally, the good effects obtained by excision of part or of all of the membrana were lost, so far as hearing is concerned, by the reproduction of the drumhead. What changes of opinion in this regard may be brought about by the removal of the incus and stapes, or stapes only, the membrana being allowed to remain *in situ*, is not yet known. Good results, however, have attended all of these modifications of otoscleronectomy.

The importance of any harmless operation that can be applied with reasonable assurance of relief in these hitherto hopeless cases of chronic catarrhal deafness, noises in the ear, ear vertigo, cannot be over-estimated.

PUBLISHER'S NOTE.

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

APRIL 15th, 1893.

ASKING the question, "Are we on the wrong tack?" a New York medical contemporary says:—"In the constant search for more exact and scientific methods which characterises contemporaneous thought in medicine is there not some danger that, with increasing knowledge of disease, we may be losing sight of the patient and his personal sufferings? In Germany, for example, the home of advanced scientific medicine, the patient is too often regarded, especially by the recent graduate, as the incidental appendage to a more or less interesting morbid process. We are not yet Germanised to this extent. For in our country it has ever been the boast of the medical profession that a practical spirit ruled its methods. We have always maintained that clinical experience and 'bedside' indications, as supplied by suffering humanity, cannot be entirely supplanted by laboratory research. But in Germany the laboratory rules the day."

The observations of our colleague appear to have been called forth by an essay in the *Münchener Medicinische Wochenschrift* by Dr. O. Rosenbach, of Breslau, called "Der Kommabacillus, die Medicinische Wissenschaft und der ärztliche Stand." Professor Rosenbach says that the practitioner has had of late to take a "back seat," while the test-tube, the microscopical slide, and other instruments of precision, often wielded by mere theorists, are usurping his powers and functions.

"The tuberculin fiasco," continues our contemporary, "is too fresh in the memory of all of us to need more than a mention here. Rosenbach says that it is absurd to treat phthisical patients as if their bacillary expectorations were the really important feature of the disease." He probably goes too far when he intimates that the presence or absence of bacilli in the sputum is of no practical significance. But it is quite true that treatment has not had much help from the bacillus tuberculosis. Any schoolboy can stain and

gloat over a few bacilli. Nevertheless it still taxes to the utmost the skill of an experienced doctor to secure a prolongation of life and comfort for the phthisical patient. "Again, with regard to cholera, it is senseless to base a diagnosis solely on the presence of the comma bacillus, and to be thus compelled to await the results of bacteriological tests before knowing what to do. Yet, during the recent German invasion, it has frequently happened that patients were dead for a day or two before the practitioner was permitted, by grace of the authorised State bacteriologists, to 'know' that the disease was true cholera. Moreover, the extraordinary fatality of cholera nostras is very suggestive of the possible fallibility of laboratory diagnosis, which disregards all clinical evidence."

Dr. Rosenbach deplores this tendency to exalt the chemist or bacteriologist above his deserts. He should be merely an assistant of the true physician. Rosenbach is strongly opposed to what he terms the diagnosis *in absentia*—that is to say, an "exact diagnosis" based exclusively on the results of the chemical or microscopical examination, for example, of the urine, the patient being quite unknown to the diagnostician. But whatever they may do in Germany, there is not much danger that laboratories will supplant physicians in this country in the near future. Nor do we apprehend that Rosenbach's fears will soon be realised to the extent of making the German doctor altogether superfluous, even if diagnostic institutes, supervised by State officials, should be called upon to decide medical questions.

MEDICAL REPRINTS was originally established as a medium of communication between its proprietor and the medical profession, by whose sanction and on whose prescription alone are sold the articles of pharmacy in which he deals. These articles are enumerated in a catalogue at the end of the reading matter in this issue, and of several of them samples are furnished free of charge to medical men on request. Attention is particularly desired to the new engraved blank Diet Table, published for the use of physicians desiring to issue special directions as to the dietary of their patients. These tables bear no advertising or other printed matter whatever, and are sold in packets of one hundred at a shilling, postage prepaid. One of these blank tables is also packed with every bottle of Lactopeptine supplied to a medical man. Lactopeptine is a specific remedy in indigestion, malnutrition, vomiting in pregnancy, and other disorders of the digestion. It is a compound of the digestive ferments, and acts by relieving the stomach of the work of digestion. It is readily dispensed by all chemists, the formula is attached to every bottle, and it is sold on medical recommendation solely. Medical men unacquainted with this remedy in practice, or those who, having employed it formerly, have lost sight of it, are invited to send for a four-shilling bottle of this palatable and effectual digestive, which will be sent free of charge by post on receipt of a postcard or other request.

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KONIGL CHARITÉ, BERLIN—THE CONVALESCENTS' GARDEN.

NEWS

AND

NOTES.

A PREACHER in the neighbourhood of Cincinnati thinks the American nation specially favoured of Providence, and consequently affirms that there is no fear that cholera will visit the States next year. The plague, he says, is sent to discipline mankind, and it begins therefore in the Far East, where everybody is very bad, and scarcely one belongs to any of the Christian denominations. But "it is rare," he continues, "that so dire a plague afflicts us, which proves that we are recipients of God's choicest blessings, and we should show we appreciate them by becoming Christians."

An amusing story (not guaranteed authentic by the present reporter) comes from a Parisian contemporary, and if not *véro* is at least sufficiently *ben trovato* to bear repetition. Some years ago, it is said, Madame Pommery, whose name is so familiar to epicures, began to utilise some waste land over her champagne cellars, for the breeding of rabbits destined to serve as food for the powder expended by her guests during the shooting season. Madame Pommery was evidently unacquainted with the rabbit scourge that has proved so detrimental to agricultural operations in Australia, or she would never have made such a hazardous experiment. Finding that the rodents above ground were fast becoming more numerous than the bottles in the famous cellars beneath, and that their burrowing threatened the stability of the said cellars, she consulted M. Pasteur. That magician, by sowing chicken-cholera broadcast among the obnoxious animals, succeeded in killing them all in a fortnight.

AN Anti-Crinoline Bill has been, it is said, presented to the Minnesota Legislature. The medical profession has also been interviewed on the subject of crinoline, but without any very productive results. It is suggested that hoops take some of the weight off the hips, and promote the freer circulation of air. They also make fat ladies more symmetrical, thus tending to lessen the practice of tight lacing.

THE Missing Word craze has had an offshoot in medical journalism. An American contemporary offers a prize in the shape of an electrical battery, value five pounds sterling, to the first of its readers who successfully adds to an imperfect formula the name of an ingredient which is omitted. The prescription, which is stated to be used by Dr. Unna in cases of humid eczema, is, omitting the doubtful ingredient, as follows:—

R	Cretæ gallicæ. (tale)	...	...	...	3ii
		...	...	...	3iv
	Zinci oxidi	...	...	...	3vi
	Adipis benzoinati	...	...	...	3xxviii
M. ft.	ungt	*	*	*	

DR. R. N. HAWLEY, in a paper recently read before the Milwaukee Medical Society, while admitting the probable influence of Dr. Hall, cited Dr. E. W. Richardson (whose remarks on the subject were alluded to in MEDICAL REPRINTS, No. 1), to the effect that Helkiah Crooke published in 1615 what was probably the first great work on anatomy published in the English language. It contains over one thousand pages, imperial quarto, and is illustrated by numerous drawings of anatomical subjects. It embraces, besides anatomy, various passages of a physiological and psychological nature. In this work the membranes of the brain are well defined and described, and the pia mater takes a very distinct place. The man who printed the works of Crooke was W. Jaggard, of the Barbican, London, who also was the printer for Shakespeare. Within easy walking distance from the Globe Theatre, the scene of the great William's managerial glory, was the printing office of Jaggard, where the plates and letter-press of Crooke would for long seasons be the most remarkable presswork of the time. To that office the indefatigable playwright would often be drawn by his own business, and there he could hardly fail to see unfolded before him the anatomy of man, from a sure source and in just the form that would most readily appeal to his ever-absorbing mind. The closer this book and the book of the plays are read together, the more clearly it is detected where and how the dramatist became the student of anatomy.

MR. JOSEPH KORÖSI, director of the bureau of statistics of the city of Budapest, has established a prize of 1,500 francs for the best essay on the object and progress of demography, which may be written in German, English, French, or Italian, and should be sent, without anything to indicate its author's identity, but presumably with a motto for identification, to Mr. Körösi before March 1, 1894.

MEDICAL LITERATURE.—III.

A BOOK OF THE MONTH.

A Manual of Diseases of the Ear, by GEORGE P. FIELD, M.R.C.S., Aural Surgeon to St. Mary's Hospital, Lecturer on Aural Surgery and Dean of the Medical School. Pp. 382, price 12s. 6d. (London: Baillière, Tindall, and Cox, 1893.)

[Specially reviewed by JAMES D. STAPLE, M.R.C.S., late Senior House Surgeon Stockport Infirmary.]

In the fourth edition of Mr. Field's work on Aural Diseases, which was received too late for more than casual mention last month, the very important advances made in diseases of the ear, since the issue of the last edition, have been fully recorded.

The book commences with an account of the anatomy and physiology of the external and internal ear, which are clearly described and illustrated; and the fact is emphasised that the meaning of the pathological changes in the organ of hearing cannot be properly understood without a practical knowledge of the anatomy of the healthy ear. The author says that the thorough examination of a patient for deafness is by no means as easy as it appears, and he has proved this by the frequent errors in diagnosis, and consequent want of good results from treatment, in cases which have been sent to him. Lauder Brunton's speculum, which is a general favourite, is strongly recommended for diagnostic purposes. The chapter on Impaction of Wax is full of practical interest to the surgeon, as this is, of course, a very common cause of deafness, and one on which a general practitioner is often consulted. To remove the wax the author advises only using a syringe, with the precaution before doing so, should the wax be very hard, of pouring into the ear a warm solution of bicarbonate of soda, at bed-time, for two or three consecutive nights. The reader is warned against the needless use of instruments, and also not to give too favourable a prognosis in all cases, as cerumen, constantly accumulating, may lead to perforation of the membrane, and even worse results. After the removal of the wax, the ear should be protected with cotton wool, for some days, or else myringitis or acute tympanic catarrh may result. On foreign bodies we read that it is far better to let them remain in the ear, for a time, at least, than to use any force in attempting removal. Instruments are seldom required, but when a foreign body is so very firmly impacted that extraction without them is impossible, anaesthetics should be given. Of osseous tumours there

is a full and complete description, and they are said to be frequently caused by some mechanical irritation (as, for example, pus in the meatus or frequent sea-bathing). The author recommends the operation of "drilling" where there is one tumour, of ivory consistence; in the case of multiple growths, as a triangular channel in the meatus is generally found, which may be kept open by other means, the operation is unnecessary. The skin diseases of the ear, which often produce deafness (eczema, herpes zoster, ichthyosis, erythema, lupus, porrigo contagiosa, erysipelas, and syphilis) are described, with their appropriate treatment. For the treatment of chronic eczema, which is sometimes so intractable, Mr. Field recommends a lotion of liquor carbonis detergens 3ij to ʒviij of water. On acute catarrhal suppurative inflammation of the middle ear, the author, after enumerating the various symptoms, describes the treatment, recommending frequent fomentations of the external meatus by pouring in, not syringing, warm water, which gives speedy relief, especially to children. Politzer's bag is spoken well of for young children, and leeches, in front of the tragus, are advised for adults. If bulging of the membrane occurs in acute suppurative inflammation, other methods failing, as Politzer's, paracentesis should be resorted to, although if the pus should make its way spontaneously through the membrane, we are assured that even a permanent opening is quite compatible with good powers of hearing. When the tympanum is perforated, cleanliness is greatly insisted upon, as with this the membrane will generally heal satisfactorily, and the syringe should be used at least three times daily. On chronic and sub-acute catarrhal inflammation, of which the former is the most common cause of deafness, Politzer's method is generally successful in mild cases. The author strongly insists on the utility of constitutional treatment, and points out the great importance of securing the automatic opening of the Eustachian tube as soon as possible, and as this is largely dependent upon the state of the naso-pharynx, the use of the Eustachian catheter is advised, but not for children. Mr. Field speaks more highly of the use of vapour of chloride of ammonium in these cases than some other authors do. The author points out the necessity there is sometimes of operative treatment of the tonsils, uvula, etc., and gives a clear and simple mode of



KÖNIGL. CHARITÉ, BERLIN—A SCENE IN THE OPERATING ROOM.

introducing the Eustachian catheter. In this chapter the treatment of this most common and obstinate complaint is most fully and carefully described, and will be full of interest to the general practitioner, who has frequently so much trouble with these cases.

In describing the perforation of the tympanum, we are told that the size of a perforation is no guide to the amount of loss of hearing accompanying it, and cases are mentioned cured by the following method: the use of often-changed astringent lotions and powders, counter-irritation behind the ears, constitutional treatment, and the use of Politzer's bag twice a week. Mr. Field gives a useful list of the artificial ear drums, and the advantages to be derived from their use; and he describes fully one of his own invention (which may be briefly described as a compound disc of india-rubber, cotton wool, and flannel), which he has found useful in several cases of perforation. The consequences following chronic suppurative inflammation are most fully entered into. On abscess of the mastoid cells, the author plainly shows the advantages that may be derived from an early incision over the mastoid process, free leeching, and constant washings with weak astringent applications. There is a most useful summary of the symptoms of cerebral abscess and sinus pyæmia, and the differential diagnosis of cerebral abscess is very clearly stated, and some highly interesting cases are quoted, illustrating the disease, to which limited space precludes fuller allusion. With regard to the symptom of optic neuritis, about which there has been so much writing and discussion, the author says that "it is present in about half of intra-cranial lesions from aural diseases, it is a valuable positive sign of head complications, especially in doubtful cases, but has little differential diagnostic value." The author has, we think very wisely, not described the technique of the operations for opening the skull, as he remarks that this would be beyond the scope of his work. Broadly speaking, he says that acute abscess gives rise to symptoms usually attributed to meningitis and encephalitis, but that chronic abscess may exist for years unaccompanied by any symptoms, until the abscess extends sufficiently near the surface of the brain to cause inflammation, this being the usual mode of termination. On the value of pain as a symptom in ear disease, the author says that there have been many cases of meningitis and abscess of the brain in adults, when a discharge from the ear has been first noticed in the post-mortem room. Undiscovered ear disease, leading to fatal results, is still more common in children, and the facts are well illustrated by some cases recorded.

Ear diseases are divided into two great groups of cases clinically:

1. Persons who seek for advice for pain in or about the ear.
2. Persons who complain of loss of hearing, including tinnitus and vertigo.

We read that "unfortunately a large number of medical men show a remarkable want of familiarity with the ear speculum, especially when we consider that cases of tinnitus, neuralgia, headache, vertigo, epilepsy, cerebral irritation, brain disease, pyæmia (due to ear disease), so frequently come under their notice, and large proportions are unrecognised." These remarks, coming from such a high authority on ear diseases as Mr. Field, deserve to receive very careful attention. On diseases of the internal ear we see that "although many recent observers have done much to elucidate the coarser pathology of the labyrinth we are still much in the dark concerning the causations of many of the symptoms of internal ear disease." The symptoms, etiology and post-mortem appearances of

labyrinthine disease, and the method of using the tuning fork in distinguishing between deafness due to mischief in the labyrinth, and deafness due to disease of the middle or external portions of the auditory apparatus, are most practically described, but limited space prevents my alluding to them more fully. The account of pilocarpine in labyrinthine disease is one of the most interesting features of the book, as is well known. Mr. Field has made an extensive trial of the pilocarpine treatment, which he has from time to time reported in the medical papers. It appears to be chiefly useful in nerve deafness. Dr. Lauder Brunton is quoted as saying that pilocarpine increases all the secretions of the body except bile; it acts by stimulating the secretory nerve fibres. Our author has proved that pilocarpine increases the secretion of wax in the outer ear, and he therefore naturally argues that the secretion of the inner ear is promoted by the drug, seeing that all the mucous membranes are stimulated by it. We are told that no treatment in labyrinthine disease, when pronounced atrophy of nerve tissue has occurred, can be of any use.

The precise mode of using the injections of pilocarpine, and the treatment during and after the effects of the drug, are minutely given, and the author says that "untoward symptoms need not be apprehended if one begins with a small dose."

Ménière's disease is well defined as "an abnormal irritation in the semicircular canals, or inflammation of these, or of the middle ear, producing vertigo." The symptoms are graphically described; the treatment used by the author—viz., attending

to any condition of the ears (for example, if there is a discharge, curing that), and using various drugs, quinine, bromide of potash, chloride of ammonium, etc.—appears to have been very successful. The causes of tinnitus aurium are well classified, and it is stated to be caused by "abnormal pressure upon the nervous expansion in the labyrinth." Pilocarpine has removed tinnitus in several of the author's cases, and he points out the importance of attending to constitutional treatment, and gives a useful list of drugs which have been of service.

Dr. Cagney has written a most instructive article on

the electrical treatment of tinnitus aurium and deafness. In the concluding remarks on this troublesome affection we read that, "Whether tinnitus be occasioned by wax, debility, chlorosis, aural catarrh, or a different cause, if the treatment be adapted to the special conditions of the ear, a cure may, as a rule, be hoped for: in aural catarrh, for example, judicious treatment by Politzer's bag, the Eustachian catheter and other appliances already mentioned, is notably successful."

In the interesting chapter on Deaf Mutism, we learn on the authority of Buxton that ten per cent. of deaf mutes are offspring of first cousins, and the extensive tables given of this disease are very interesting and important. The various systems of instructing the deaf and dumb are briefly but sufficiently explained. The author in the chapter on Aids to Hearing admits that, after many years' practical experience, trumpets and tubes alone excepted, other aids to hearing are useful in only a very small proportion of deaf persons, although there have been a few brilliant exceptions.

The illustrations of this book are numerous and excellent, and most helpful to the reader; the coloured ones are deserving of especial praise. Mr. Clarke has executed several of them for this edition. In concluding this review, I would, therefore, most strongly advise readers to procure the book for themselves, as it is eminently essential for all practitioners to have a complete, practical, and trustworthy treatise on aural diseases, and I have no hesitation in saying that he will not find a more useful guide than the work of Mr. Field.



OUR ILLUSTRATIONS.

A BERLIN HOSPITAL.

OUR illustrations this month have for their subject the Königl. Charité, Berlin, and consist of a *fac simile* reproduction from a wash drawing of the exterior view of the hospital, a wood-engraving of a scene in the operating room, where the dressing of a surgical case is seen in progress, a pleasing representation of the garden and of the convalescents to whose use it is devoted, and finally a touching and characteristic study of the women's ward on a visitors' day. The engravings have been executed from drawings made on the spot.

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

BURNS.—Dr. Von Bardeleben recommends in burns of moderate severity the use of a powder of equal parts of sub-nitrate of bismuth and powdered starch. The burns are thoroughly cleansed, then washed with a three per cent. carbolic, or three per cent. salicylic acid solution. The blisters that are present are then removed under antiseptic precautions and the above powder thoroughly applied. This is covered with layers of cotton, which are removed as they become saturated with the secretions, except the one next the wound. This dressing may remain undisturbed for one to two weeks, or even a month. In most cases, pain disappears a few hours after applying the bismuth. In burns of the face the writer uses the powder, with no other dressing.

TREATMENT OF VOMITING.—Dr.

H. B. Lowry says (*Kansas Med. Index*) that for vomiting, arising from various causes, but especially that of gastritis, pregnancy, and phthisis, the remedy *par excellence*, the action of which, when all others have failed, is indeed most gratifying, is tincture of iodine, ten drops to be taken in water, in divided doses after meals. In the graver lesions of the stomach, such as dilatation, gastric ulcer, cancer, etc., there is much minutia in the treatment, as regards diet, drugs, their methods of administration, and the position the patient should assume under certain conditions, to which the conscientious practitioner must give due diligence. He also calls attention to the discussion that has been going on of late in regard to internal antisepsis, the opinion of the German physicians being that it is very doubtful whether antiseptics given by the mouth ever reach the intestine; they are probably absorbed in the stomach; however, calomel

given with this view, where the trouble was not serious, has been thought to be beneficial. In several severe cases of dysentery in a London hospital, after utter failure with the use of opium, lead, ipecacuanha, and bismuth, there was tried an enema of alum—half an ounce to the pint of water, twice daily, and in each instance complete recovery resulted. In one instance the disease had been of many years' standing, but the result was equally gratifying.

TREATMENT OF SEBORRHOEA OF THE SCALP.—In cases of seborrhoea of the hairy scalp, with a tendency to alopecia, the following method is advocated:—At night scrub the roots of the hair energetically with alkaline solution of green soap, and pour on a little tepid water to cause the soap to foam. Leave this foam on the scalp for a few minutes. Remove with tepid water and apply the following salve:—

B	Flowers of sulphur	...	...	...	grs. xlv. — 7jss.
	Lanoline	...	...	...	grs. xlv.
	Benzoated lard	...	...	...	3j.

This salve prevents the formation of crusts in excess. If the patient suffers from pruritus, add 5 to 8 grains of salicylic acid, previously dissolved in alcohol. Wash the hair and apply the salve, at first every day, and later every eight to fifteen days. —*La Riforma medica.*

CATHETERS may be fastened in the urethra by tying a thread about them after introduction, painting a few coats of collodion over the knotted part with a thin layer of cotton between, and fastening both ends of the thread to the penis in the same manner.

CONCENTRATED SOLUTION OF BORIC ACID.—A saturated aqueous solution of boric acid, prepared at ordinary temperatures, contains, as is known, approximately four per cent. of the acid. To prepare more concentrated solution, Scholtz and Mansier recommend the addition to the mixture of boric acid and water, before boiling, of $1\frac{1}{2}$ gm. of cal-

cined magnesia for every 10 gms. or fraction thereof beyond the normal quantity of 40 gms. per 1,000 gms. of water. The calcined magnesia may be replaced by the carbonate of magnesium, according to Ploux, who suggests the preparation of a stable solution—containing 100 gms. of boric acid in a litre of solution—as follows:—

Boric acid	...	...	...	100 parts.
Magnesium carbonate	...	...	...	11 parts.
Water	...	...	...	1,000 parts.

Even a twenty per cent. solution of boric acid can be prepared, thus:—

Boric acid	...	...	...	200 parts.
Magnesium carbonate	...	...	...	35 parts.
Water	...	...	...	1,000 parts.



KÖNIGL. CHARITÉ. IN THE WOMEN'S WARD. VISITORS' DAY.

CORRESPONDENCE.

DEAR SIR,—You were kind enough to forward me, a short time since, a sample bottle of your Lactopeptine, for which I am much obliged. I am glad to be able to inform you that it has proved of signal service in an obstinate case of chronic dyspepsia at present under my care, and I shall certainly recommend it in future in similar cases.—Yours faithfully,

J. M. WALKER, M.B.

4, Be'grave Road, Edgbaston, Birmingham, Jan. 28th, 1893.

BACK NUMBERS OF MEDICAL REPRINTS.

The following issues are out of print:—

No. 1 (February, 1890). No. 14 (March, 1891).
No. 7 (July, 1890). No. 17 (June, 1891).
No. 10 (November, 1890) No. 19 (August, 1891).
No. 13 (February, 1891). No. 22 (November, 1891).

Any other back number will be sent post free to any medical man on receipt of three penny stamps.

[For contents of numbers dated earlier than January, 1893, see former issues of MEDICAL REPRINTS.]

No. 36 (January, 1893) contains:—

Therapeutic Value of Lactopeptine. By Edward A. Piggott, L.R.C.P. and S. Edin., &c.; Case of Anteversion. By H. Hobart Dorman, M.D. Dub., &c.; Excision of the Ossicula in Chronic Aural Catarrh; with instance of a failure. By H. V. Wurdemann, M.D. Diagnosis of Spinal Cord Lesions. By F. Peterson, M.D. (With Five Illustrations).—Case of Late Hereditary Syphilis, with Nasopharyngeal Lesions. By J. F. Klinedinst, M.D. (With an Illustration).—American Opinion.—News and Notes.—Continental Practice.—Therapeutic Notes.—Portrait: Sir Richard Owen.—Views: Sheen Lodge.—The Northern Hospital, Liverpool.—The New Psychiatriche Klinik, St. Petersburg.—Index, Frontispiece, and Title-page to Volume III.

No. 37 (February, 1893) contains:—

Were Protoplasmic Reversions checked by Alcohol? By Wm. H. Pearce, M.D. Edin., &c.; Early diagnoses of Mastoid Disease. By D. Milton Greene, M.D. (With an Illustration).—Diseases of the Frontal Sinus. By D. N. Rankin, A.M., M.D., &c.; Case of Ununited Fracture of the Femur. By W. Treacy, M.D.; Medical Literature.—I. A Book of the Month. Reviewed by J. E. Bullock, M.D. Brux, M.R.C.S. Eng., &c.; News and Notes.—American Opinion.—Therapeutic Notes.—Portrait: Dr. William M. Polk.

No. 38 (March, 1893) contains:—

Constipation. By J. D. Staple, M.R.C.S. Eng. (Original Article).—How Amputation of the Breast for Carcinoma should be Performed. By Prof. R. F. Weir, M.D. (With Two Illustrations).—Spontaneous Cure of Multiple Papillomata of the Larynx after Tracheotomy; with the rare Anomaly of Papilloma of the Epiglottis. (With Four Illustrations).—Medical Literature.—II. A Book of the Month. Reviewed by E. A. Piggott, L.R.C.P. and S. Edin., &c.—Pooks.—News and Notes.—American Opinion:—Digitalis in Pneumonia; Barium Chloride in Epilepsy: How to Cure Eczema.—A New Disinfectant Soap.—Therapeutic Notes.—Views: The Bristol Medical School: Exterior, Entrance Hall, and Lecture Theatre.

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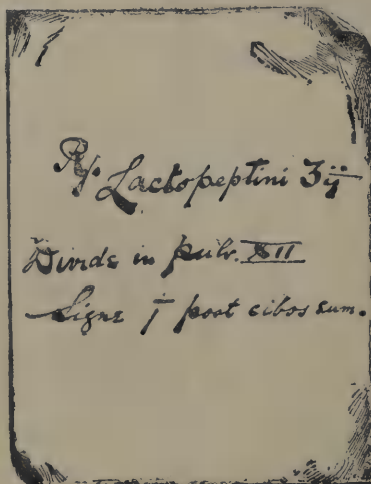
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Each pint bottle of "SUCCUS ALTERANS" (McDADE) contains in natural combination the unimpaired virtues of sixteen troy ounces of the true medicinal plants, *stillingia sylvatica*, *smilax sarsaparilla*, *phytolacca decandra*, *lappa minor*, and *wanthoizylum carolinianum*, collected in their native growth under the personal supervision of Dr. G. W. McDade, and manufactured while still in the green state, the compound being made in the same proportions as indicated in the original formula, published by Dr. J. MARION SIMS in the *British Medical Journal*, March 10, 1883, and endorsed by Dr. B. RUSH-JONES, and many other eminent physicians. It is certified by DR. McDADE as a strictly trustworthy and uniform preparation, made only from green drugs collected in proper season, and is the only preparation from which the remarkable results obtained by Dr. MARION SIMS and others can be relied upon.

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JOHN G. MARSHALL, B.A.CANTAB., M.B., M.R.C.S.ENG.

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For diseases having their origin in a syphilitic source, I believe the "Succus" to be the one reliable specific, for I may add that invariable success has been met with by me when prescribing the remedy in question, even after the failure of all other alteratives.

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In one case of specific disease of many years' standing, my patient had been obliged to take Pot. Iod. in large, depressing doses ever since the onset of the attack, and it really seemed that he would be doomed to a life of Iodide of Potassium. I gave him "Succus Alterans McDade," and in three months he was a different man; in six months he was practically cured, and he has been enabled to do without the Iodide ever since the commencement of the new treatment. As an alterative tonic its effect is simply splendid.

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PIL APHRODISIACA (LILLY).

Formula.—B. Ext. Damiana, 2 grs.; Phosphorus, $\frac{1}{10}$ gr.; Ext. Nux Vomica, $\frac{1}{2}$ gr.
Dose.—One to three pills, three times daily, with food.

Indicated in MENTAL OVERWORK, SEXUAL DEBILITY, IMPOTENCY. Decidedly beneficial in cases of NOCTURNAL EMISSIONS, the result of excess; in MENTAL APATHY or indifference, and in an ENFEEBLED CONDITION OF THE GENERAL SYSTEM, with WEAKNESS or DULL PAIN in the LUMBOSACRAL REGION. Also act in the female as a UTERINE TONIC; hence indicated in LEUCORRHOEA, AMENORRHOEA, DYSMENORRHOEA, and to remove the tendency to repeated miscarriage.

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Price.—Bottles of 100, price 4/6. To the Medical Profession, 3/9; post free, 4/-.
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Your LACTOPEPTINE I value very much, and have prescribed it largely, especially in diseases of children accompanied by wasting and persistent diarrhoea. I have a large number of children as patients in my practice, and I have found your LACTOPEPTINE many times a "sheet anchor" in infantile dyspepsia.

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I have been so much pleased with the results of my trial of LACTOPEPTINE, that I feel it my duty to inform you of my success. One case in particular I wish to refer to. The patient had been a sufferer from atonic dyspepsia for the last six years. She had tried many of the best preparations without any marked benefit. Recently she placed herself under my care, and I put her upon your much-praised LACTOPEPTINE. To use her own words, "Nothing she has ever taken has done her so much good."

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I have been for years in the habit of using LACTOPEPTINE, and can testify to its very great value in dyspeptic cases.

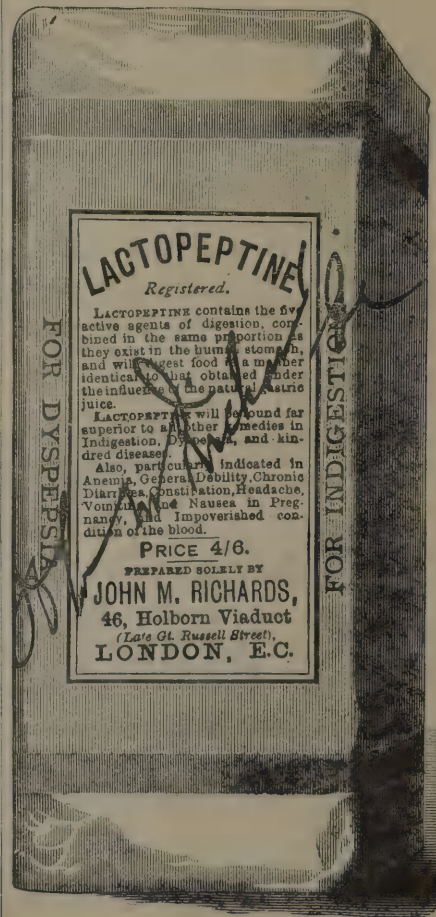
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LACTOPEPTINE is dispensed by Chemists as a matter of course, just as readily as quinine or any other drug, and is consequently prescribed by Medical Men in exactly the same manner.

JOHN M. RICHARDS,
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A Combination
of all the
Digestive Ferments:
Its Pepsin the
most active known,
its Pancreatine
equally potent;
cures in
Intestinal Dyspepsia,
and in cases
where Pepsin alone
has no value.



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MEDICAL REPRINTS

Home, Foreign, and Colonial: with Original Essays.

VOL. IV.]

LONDON: MAY 15TH, 1893.

[No. 40.

DYSPEPSIA AMONG THE TEXTILE TRADES OPERATIVES: ITS CAUSATION AND TREATMENT.

By J. A. DIGGLE, L.S.A. Lond.

[An Original Article specially written for MEDICAL REPRINTS.]

I SHOULD think that no class of general practitioners in all England sees so much of the disease which gives its title to this paper as those whose practice lies in the great centres of the Textile Industries; and especially those centres which are identified most prominently with the spinning and manufacture of cotton goods.

There are several reasons why the operatives engaged in these trades are so subject to dyspepsia, and it will be my aim to bring these forward.

I am the more emboldened thus to trespass on your attention as amongst all the essays on this subject I have read lately I have seen none which treat of it from the standpoint of the ordinary general practitioner and his poorer or working-class patients.

The diet tables and rules of procedure which are laid down in so many articles are in this class of cases almost useless, owing in many cases to the ignorance of the patients, and in others to their inability to procure certain articles of diet which are recommended. Test meals in a morning are here inadmissible, and warm or cold douches it is impossible almost to get the patient to try. And another great drawback of which I will have more to say hereafter, is the want of proper knowledge of cookery.

Passing now on to the principal causes of dyspepsia amongst the classes I am considering, I may formulate them under three heads, and these, in perhaps the order of their importance, are:—

A. Their work. B. Their food. C. Infantile rearing and (2) Heredity.

A. THEIR WORK.—This I take first for two reasons, firstly, because it is in a great measure the circumstances and necessities of their work which cause the use of so much improper food, and which, secondly, affects the offspring through the parents.

The heat and, in some departments of the trades, the dust which the workers are continually among causes an intense thirst, which, as the worker cannot leave the mill, he or she is compelled to quench by copious draughts of water, herb beer, or tea, which latter has in most cases been standing in the tin cans it is brought into the mill in since the previous mealtime.

Another cause of indigestion, among the males at all events, is the habit of chewing tobacco. This is indulged in mostly in the preparation rooms, where the most dust is and the heat not so great. Looking at the waste of saliva caused by the constant spitting, it would be a wonder if the salivary glands were always in good order, and their secretion in a fit and active state for admixture with the food eaten.

B. FOOD.—A good deal of the improper or excessive use of certain foods (pastry, pickles, sauces, &c.) is no doubt caused by the work in which they are engaged necessitating or creating a desire for sapid and savoury articles, but after this is granted there is a great need for reform, and care in the diet of these people. The great faults are:—

1st. The excessive use or the abuse of tea.
2nd. The inordinate eating of pastry and sweet cakes of all sorts.

3rd. The evening meal at home is the only one in the day over which even a reasonable time can be spent, and in many the bad habit of hurry has got so implanted that this is bolted.

4th. Ignorance of proper cookery. This is hardly to be wondered at in many cases, since the women have nearly all spent their earlier years in the factory, when they should have been learning to cook, and it is only when they get married that their attention is turned in that direction, and it is generally considered that if a woman can knead and bake a batch of bread and make a potato pie she has learned enough

C. HEREDITY AND INFANTILE REARING.—You cannot get healthy children from unhealthy parents; weak, under-sized, and in many cases already dyspeptic. Weak constitutions show themselves in many ways; sufficient for me to refer to the early decay of teeth in connection with this subject.

Infantile rearing opens up a very wide subject, far too wide for me to discuss fully here; but what I want to bring out is the mistakes (from ignorance in part) which make the children of factory-workers dyspeptics, from their birth almost.

Few of the women, having two or less children, stop at home. They go to work like their husbands, and the unfortunate babies are handed over at five in the morning to some old woman (past all other work generally) who takes charge of them till night. In some cases the mother will go in the course of the day and give the child the breast, but what virtue can there be in the mother's milk after being churned in the breast for perhaps a whole morning whilst in the mill? In fact, I have been obliged to stop even this sometimes, for the mother's milk (the true food) did the child more harm than good.

The general food of these children so put out is milk and water, or so-called "pobz," boiled bread, often with no milk at all mixed with it. In fact, I have seen a large coffee cupful of nothing but semi-solid boiled bread forced down a child's throat at not a month old, and I have been repeatedly met with a look of astonishment when I have asked, "Do you put no milk in the bread?" What can be expected from such feeding but infantile dyspepsia and diarrhoea, and in many cases gradual wasting and death?

This will suffice to show that the up-bringing of the children is not always of a kind to make them strong and sturdy, and fit to encounter the drawbacks of a factory life.

THE TREATMENT OF DYSPEPSIA.—This will resolve itself roughly into two divisions, according to the class of the disease, whether, as Dr. Dujardin-Beaumetz divides it, the form be irritative dyspepsia, or atonic or atrophic dyspepsia, the first being characterised by hyperchloridia (excess of hydrochloric acid), cramps, pain, vomiting, and diarrhoea. The second, on the contrary, by achloridia (deficiency of acid hydrochloric), paresis of the muscular coat, putridity of faeces and eructations, and often constipation.

The treatment of the first may be included under the following heads:—(a) To relieve the symptoms, pain, sickness, &c. (b) To regulate the diet. (c) To remove the cause, if possible, or at least to provide such artificial aids as shall conduce to perfect digestion. (d) In cases amongst such subjects as I am considering it is almost a necessity to begin by relieving the urgent symptoms, as it is almost impossible for a man to attend to his work properly if suffering from pain, sickness, or cramp. In such cases I generally begin with the following mixture:—℞ sodæ bicarb. ʒij, bismuthi subnitrat. ʒij, ac. hydrocyan. P.B. ℥viii, tinct. opii, ℥xxv., xxx., aq. menth. pip. ad. ʒviij. This in most cases has the desired effect, but when, as is often the case with women, constipation is present, I substitute pulv. rhei ʒss for the bismuth, or sometimes give a dose or two of mist alba. This generally succeeds, and I find nothing in the earlier stages of irritative dyspepsia to act better. Occasionally cerii oxalas in place of the bismuth may have a beneficial effect; or if there is very little pain the tinct. opii may be omitted.

(b) To regulate the diet.
This is in very many cases the hardest part of the treatment. It is easy to say what a patient must not eat or drink, but it is difficult in many cases what to not allow but what to order when there is both the patient's pocket and his cook to consider, and if the remarks I made before as to the cookery among the factory workers applied when in health, how much more do they tell when a weak stomach has to be considered. The excessive tea drinking has to be cut off, and cocoa substituted at one meal at least, and the tea to be made fresh and taken with plenty of milk. For dinner I suggest hop-ale or dandelion beer or malt liquor. I also endeavour to cut short the tobacco chewing, and impress on them the thorough

mastication of their food. The diet I order is plenty of milk, eggs, vegetables, and fruit, and in mild cases well-done meat.

I also interdict all pastry, pickles, &c., and especially new bread and hot tea-cakes; and order crisp toast with little butter, or, as a change, milk biscuits.

Fish, if I can get them to cook it properly, I allow, but it is so often baked in the oven with excess of grease that in many cases it cannot be taken. Tripe, which is a great and favourite dish amongst all the class I am considering, I also allow in some cases.

(c) To remove the cause, or at least to provide artificial aids to digestion. Here I come to the most important part of my subject. It is impossible to alter a great many of the conditions under which these people live, and which conditions are a fruitful source of the disease we are considering, and so, as they must work to live and cannot always (if they would) change their work, we are driven back in our treatment to try for something which will, in despite of these conditions, enable them to eat and digest sufficient food to replace the waste and supply the wants of the body, sufficient to enable their task to be done.

Many such artificial aids to digestion have been put forward, and for many years I had been in the habit of prescribing pepsin in some form or the other, and although in some cases it acted well, yet such differences appear in the various sorts sold, that many times I found it almost useless. About four years ago I had my attention called to a combination of the different digestive principles in one drug, a powder called Lactopeptine, which was very satisfactory, so much so, in fact, that I have used and recommended it ever since. In these cases I have just been considering it acts like a charm, and a short exhibition of it has been sufficient in many cases of irritative dyspepsia to enable the patient to go for, in some cases, twelve months without a return of the complaint.

It is, however, the impossibility of these people getting away from the exciting causes of dyspepsia that in so many cases carries them on into the second class of this disease, that atonic or atrophic variety, which is so much the more hopeless of cure; but it is in this class that we find the true value of Lactopeptine.

Characterised as this variety is by the deficiency of hydrochloric acid, and in the atrophic form by the want of both secretion of pepsine and the normal peristaltic action of the stomach, a glance at the formula of Lactopeptine shows at once that we have in it just what is wanted to put into the stomach in order to ensure proper digestion. I have a patient now who twelve months ago dare not eat a piece of meat at all, but who to day can eat a hearty meal of meat and potatoes, provided he has his dose of Lactopeptine; in fact, this man dusts the powder over his food on his plate like shaking pepper over, and mixes it up in that way thoroughly with the food.

In such cases as the above I generally begin with a mixture of Lactopeptine, as follows: \mathcal{R} Lactopeptine \mathfrak{z} iss, spiriti chloroformi \mathfrak{z} j, aqua \mathfrak{z} vj, and \mathfrak{z} j t.d.s. postcibus.

This quantity lasts two days, three meals a day, and I think there is no fear of any degenerative change taking place in it in that time; possibly the sp. chlorof. would assist also in preventing anything of the sort.

Formerly I had been in the habit in such cases of depending largely on pre- or partially digested and peptonised foods, and beef juices or jellies, but, apart from the cost, which itself was a great drawback among the class of persons I am considering, there was a general expression from the patients that such foods did not fill them, as in their ignorance they supposed a sufficient quantity of food had not been taken unless the stomach felt distended. Now I let them have eggs, well-cooked meat, and farinaceous foods, and with the above-mentioned mixture taken at the same time I have had very good results.

After about a week on the above mixture I put the patient on the following: \mathcal{R} Ac. hydrochlor. dili. \mathfrak{z} iss; Sp. chlorof. \mathfrak{z} j; Inf. gentianæ, \mathfrak{z} j; \mathfrak{z} j t.d.s. before meals and Lactopeptine gr. v after meals.

In purely atonic cases, in which the stomach simply requires rest to regain its normal state, this acts very well, and after a short time I drop the acid mixture and order the powders to be taken occasionally if required. In severe atrophic cases, however, in which the pepsine secreting power of the stomach seems altogether lost, I keep up the doses of Lactopeptine to ten and often fifteen grains.

I notice in the "Medical Annual" Dr. Ewald mentions a case in which examinations of the contents of the stomach, both during and after a meal, failed to detect either pepsine or peptones, and yet, strange to say, this man felt very little of the ordinary symptoms of dyspepsia, and Dr. Ewald accounts for it by supposing that the food passed so quickly

out of the stomach as to cause no inconvenience, and that all the digestion was carried out by the post-gastric secretions.

Such cases, however, must be rare—rare, I mean, in the fact of the patient suffering so little inconvenience—and it appears that these are just the cases in which Lactopeptine is so very useful; in these, however, the larger doses must be given, even up to twenty grains after each meal. In those in which at first there are very foul eructations or foetid fæces, I generally give a few pills as follows:—Chloro-phenol. gutt. i (Hargreaves), made into a pill with bread-crumbs, being volatile it soon spreads through the intestine, and, until the digestive aids have got fully to work, it keeps the secretions sweet.

I do not know that there is any use in instancing individual cases, though I could find notes of a dozen or more; one, however, I will just mention briefly.

M. E., a carder's wife, herself a former factory operative, I found suffering agonising pains from colic and cramps in the stomach; the pain was so severe, as she expressed it, "she couldn't live long." She had been baking in the afternoon, and had eaten some new tea-cake. Brandy and ginger had been given, but ineffectually. I immediately gave her a morphia quarter-grain subcutaneous injection, which relieved her in a very few minutes, and then the soda and rheum mixture I have before alluded to.

Next day she was better. I had never attended her before, but found on enquiry that she had had several such attacks before, though not quite so severe, and had to be most guarded in her diet. I gave her some Lactopeptine powders gr. x, and told her to take them occasionally; and she has since told me they have done her so much good that she can now with their help eat meat, potatoes, and even pork, which latter she had not been able to touch for years.

In conclusion I may say I value Lactopeptine above any digestive aid I have ever yet come across. I have tried Ingulvin, Malto-pepsyn, and the Papaw preparations, but none have given me such good results as it has.

In the wasting diseases of children from improper feeding, it has a marvellous effect, and, combined with a more rational diet, I have seen poor half-starved looking creatures change in the course of a few weeks so as to be almost unrecognisable by their own parents. These conclusions have not been come to hastily, or from insufficient experience. I have tried Lactopeptine now thoroughly for three years, and as for previous knowledge, I may say I have been engaged in practice among the classes I have been considering for the last sixteen or seventeen years. I hope my results may be of benefit to others in the same class of practice.

ON THE IMPORTANCE OF EXAMINATION AND FLUSHING OF THE GENITAL TRACT DIRECTLY AFTER LABOUR.

By ALEXANDER DUKE, F.R.C.P.I., &c., Ex-Assistant Master, Rotunda Hospital, Dublin.

[An Original Essay specially written for MEDICAL REPRINTS.]

I THINK it will be generally admitted by obstetricians, that considerable injury may occur to the genital tract during the course of any labour unobserved, and remain undiscovered till long afterwards. My object in writing this short paper is to call attention to the value of examination and flushing of the parturient canal *directly after labour* as a preventive treatment of "puerperal septicæmia."

We all know the difficulty when septic symptoms arise of determining with certainty the cause, but if such cases had been examined (as I advise), we should at least have the satisfaction of being able to state whether any breach of surface existed, and be enabled to treat same at once, and so by the method of exclusion shut off one of the most common sources of danger prevalent. In all cases I have seen in consultation with general practitioners where septic symptoms were undoubtedly present I was able to discover one cause at least, viz., a breach of surface either in the cervix-uteri, the vaginal walls, or perineum, through which (in my belief) the morbid secretions were absorbed, and inoculated the patient. On the old-established principle of "prevention better than cure," I maintain it will be safer for the patient, to flush the uterus and vagina in all cases both of labour and miscarriage, and then examine for any injury done, directly afterwards. We are then in a position to do something in time, and not wait for septic symptoms to develop when it is more than probable our efforts to cure will be thwarted or be too late.

No examination of the genital canal is made as a rule directly after labour, and if the perineum is intact it is then concluded that all is well when even an inch higher up a large torn surface may exist.

Washing out the uterus with plain hot water (previously brought to boiling point) will remove at least some of the sources of danger, and leave the parts in a much better condition for visual examination afterwards.

The *débris* removed by the flushing will satisfy the attendant that the proceeding was not only justified, but advantageous, the hot water stimulating the patient, producing contraction, cleansing the uterine cavity, and last (but not least) setting the practitioner's mind at rest by his being able to know for certain that nothing which should come away was left behind.

The facility with which the flushing and examination can be made directly after labour is certainly a strong argument in its favour. No objection will be raised by the patient, and the parts being relaxed, and os open, there will be no difficulty in inserting the tube of syringe, and the thorough cleansing of the parts will save the trouble of the proceedings later on, when it will be found much more difficult a matter, and far more irksome to both patient and attendant.

The quantity of *débris* removed by the flushing will surprise anyone who has not previously adopted the plan, and this even in cases where there was no difficulty whatever with the birth of the placenta. I may allude in this connection to the mischievous plan I have seen adopted by many midwives—viz., that of "making a rope of the membranes" (though not condemned as yet, I regret to say, by any of the text-books or manuals on the subject with which I am acquainted). The fact of rotating the placenta when extruded, or nearly so, brings on a uterine contraction; as the membranes which have not left the uterus are gripped by the os and cervix, the twisting is continued till the membranes break, leaving a considerable portion behind, setting up after-pains, which, if not sufficient to expel for good and all the offending portion, allow it to become a source of extreme danger to the patient, by subsequent decomposition, as shown by the high temperature, rigors, &c., &c.

A lacerated cervix may also exist, and a decomposing piece of membrane lie in contact for days with this open surface, all of which could be avoided by the timely flushing of the uterine cavity and the repair or cauterisation (according to the severity of the lesion) of any breach of surface found to exist. The advantage I have found from the proceeding recommended has compelled me to adopt it as a routine treatment in all cases of labour or miscarriage I attend. I first flush the whole genital tract, then examine by tactile and visual examination for any injury. Torn surfaces, such as lacerated cervix or perineum, I bring together with catgut sutures and dust with boric acid or iodoform. Slight tears I cauterise with strong carbolic acid and paint subsequently with a mixture of benzoic acid and collodion. By this means I consider I give the best chance to my patient and save my mind a good deal of unnecessary anxiety. Should I be called to see a case where septic symptoms have developed I flush and examine for broken surfaces, and cauterise such surfaces *then*, thus preventing (if possible) further ingress of morbid matter into the patient's system. Direct the uterus and vagina to be syringed twice daily (till symptoms abate) with equal parts of peroxide of hydrogen and hot water. Put the patient on teaspoonful doses of sulphurous acid every two hours till patient smells of sulphur, and by this means I certainly consider I have saved several cases and can recommend with confidence a trial of such a treatment.

Cheltenham.

THE RESULT OF EXAMINATIONS OF SEWER GAS WHICH ESCAPED IN TENEMENT AND PRIVATE HOUSES, WHEREIN CASES OF DIPHTHERIA OCCURRED.

Read before the Section of Hygiene, New York Academy of Medicine, November 23rd, 1892, with demonstrations and stereopticon illustrations.

By LOUIS FISCHER, M.D., Instructor in Diseases of Children, New York Post-Graduate Medical School and Hospital; Attending Physician to Children's Department German Poliklinik; Resident Fellow Academy of Medicine, &c.

A QUESTION which confronts us frequently is, How is diphtheria developed? and another, of equal importance, is, How is it that diphtheria most frequently infests those portions of the city wherein we have an overcrowded, an improperly fed, a poorly clothed, and a mass of people whose sleeping apartments are badly ventilated? Then we have the facts that most people invariably close their windows and doors at night to avoid "catching cold," as they term it, but prefer to inhale the stifling odours emanating from one another's breath, or expired air, and if, as it is at present, the sink is near the bed-

room, and all sewage and refuse have been emptied into it, we know also that they inhale all sorts of noxious odours therefrom. Can we not infer from this that some micro-organisms escaping in this sewer-gas, if present, might be inhaled? Clinically we recognise the condition known as carbonic-acid-gas poisoning, which is produced by inhaling air expired from the lungs and inhaled continually, producing that drowsy condition or heaviness on arising in the morning.

The following case occurred in November, 1891. I was summoned to attend a child in Avenue A, and after a careful clinical examination, diagnosed the case as diphtheria. Upon inquiring into the cause of this infection, I found that this child (an only child) was not exposed to any other sick child suffering with diphtheria, that the mother and father were perfectly well, and that no reasonable cause could be assigned to this sudden development, but the mother informed me on the following day that she had learned from another tenant that a child had diphtheria the winter previous, which lived in the same apartment, that ano her case developed within a few days on the floor above and on the floor below on the same side of the house.

The diagnosis was satisfactorily settled clinically, and finally verified bacteriologically. Upon examining the apartments occupied by this family I found that they consisted of a sitting-room, a kitchen, and a bedroom, the kitchen intermediate between sitting-room and bedroom, and in this kitchen there was a pump to serve fresh water, and a sink to catch all soiled water. Underneath this sink there is a trap which serves as a reservoir to absorb noxious gases coming from the sewer. When, however, this is not flushed with water or infested with polluted water this will settle in the trap and only require the heat of a stove in winter to develop these germs. This trap then answers the purpose of a culture-medium, for some time ago a plumber showed me a layer of mud three-fourths of an inch deep in one of these traps, which was nothing less than filth, which was constantly precipitated by water flowing through this trap or pipe. So we now have the following factors:—

1. A sudden development of diphtheria in a previously healthy child.
2. The existence of a stench arising from sewer gas in the same room wherein our patient sleeps and lives, especially on stormy days; and co-existing poor ventilation.
3. The fact that cases of diphtheria have previously developed at different times in this same house on different floors.

During a general discussion on diphtheria in the Section of Pediatrics of the New York Academy of Medicine, February 11, 1892, I said that I had collected germs in the air of rooms where diphtheria existed, and in an adjoining room, some of which were the Klebs-Löffler bacilli, others of a different nature. Culture-tests were made and the animals died with the usual symptoms.

This had occurred in tenements where the disease broke out successively on different floors and was seemingly spread by way of the sewer-pipe leading up through the house. On the other side of the hall diphtheria did not break out.¹

Let us consider how diphtheria develops and then we can reason.

Suppose a child is sick with the disease, the mother or nurse attending it will naturally, during the disease or after it terminates, wash the patient's clothes in water, and this soiled water is poured away—where? Into the waste-pipe.

If the child coughs or has its throat swabbed the cuspidors are ordered to be cleansed with water; the refuse is poured into the waste-pipe. Some carbolic acid may be used with it, but in ninety-nine times in one hundred it is wanting.

Some time ago I made a very interesting observation. A child with septic diphtheria had been ordered local applications of tanno-glycerine, applied with a camel's-hair brush. This brush always removed pieces of membrane containing these virulent bacilli, and the physician, expecting great success from his treatment, had ordered that the camel's-hair brush be taken to the water-pump, and plenty of water allowed to run through the fibres to thoroughly cleanse it. How successful he was I might tell you when I took the brush and made some cultures from a few bristles, and found them swarming with bacilli, dust cocci, and other micro-organisms. This taught me two things; first, that tannin was useless in the treatment of diphtheria; second, the danger arising from swabbing a diphtheritic throat with a camel's-hair brush.

Now, how frequently do we have pieces of diphtheritic membrane coughed up while we examine our patients, and how

¹ See Report in the Archives of Pediatrics, March, 1892, p. 219.

many pieces of membrane may be so discharged? and, again, remembering younger children cannot expectorate, but swallow the membrane, and either have a diphtheritic gastritis develop, which is rare, or, which is the most common, have the diphtheritic membrane pass through the intestinal tract, and to be evacuated at the movement of the bowels. Should membranes, then, be evacuated with the fæces, where do they go but into the sewer or closet?

Frequently I have seen children, after examination of the throat, cough or hawk and spit on the floor—sometimes in houses having carpeted floors, and sometimes on bare floors. This is not immediately cleansed, and the membrane, drying, will allow numbers of bacilli to be liberated, which, through inhalation, can cause a direct infection.

When we consider how many millions of bacilli are contained in these membranes it is easy to understand why some few might not be exterminated and maintain vitality enough to again develop.

WHEN DOES DIPHTHERIA MOSTLY APPEAR?—A. Jacobi ("Treatise on Diphtheria," p. 50) says: "Filth contributes to the generation of diphtheria as it does to dysentery and typhoid fever. He also says (p. 33) that the majority of cases have occurred in winter and spring.

If this be so where do you suppose the patients are infected? Do you believe they are infected on a cold day in the street outdoors where we have plenty of ventilation, or would it be more rational to suppose they were infected in a warm room in winter?

We know if we wish to develop the bacillus of diphtheria that we must place our cultures in the thermostat and have it warm, or nothing will grow.

THE METHOD OF EXAMINATION.—Koch's method is to examine the air contained in a certain room by allowing it to come in contact with narrow glass cylinders containing sterilised nutrient gelatine, and after a certain length of time the gelatine is covered with cotton and the colonies are allowed to grow, after which they are examined. In this way colonies grow—they can be counted and studied.

This procedure has been modified by Hesse, who uses glass tubes, 70 ctm. long and 3.5 ctm. wide. He sterilises them in steam and allows the gelatine to congeal on the sides of the cylinder by turning in ice-water, until there is formed a uniform

Petri glass, which was covered with a layer of agar-agar (sterilised), and fastened it to the trough by a layer around the outer border of collodion—or sometimes paraffin, previously melted.

This was left *in situ* about two days, giving careful direction not to disturb this by either allowing water to flow over or otherwise.

After a few days I noticed a distinct growth; I transferred the Petri glass to the thermostat and then allowed my colonies to grow. To my surprise I was gratified to find colonies of almost a pure culture of streptococci, and in one case the characteristic Löffler bacillus. This found, I proceeded to test the virulence of the germs by inoculation. A rabbit weighing four pounds was inoculated in right pleural cavity with germs of Löffler bacillus and died with characteristic symptoms of diphtheritic infection, *i.e.*, effusions into pleura, hæmorrhages, and also paralysis; locally, at seat of the inoculation, a small membranous deposit was found.

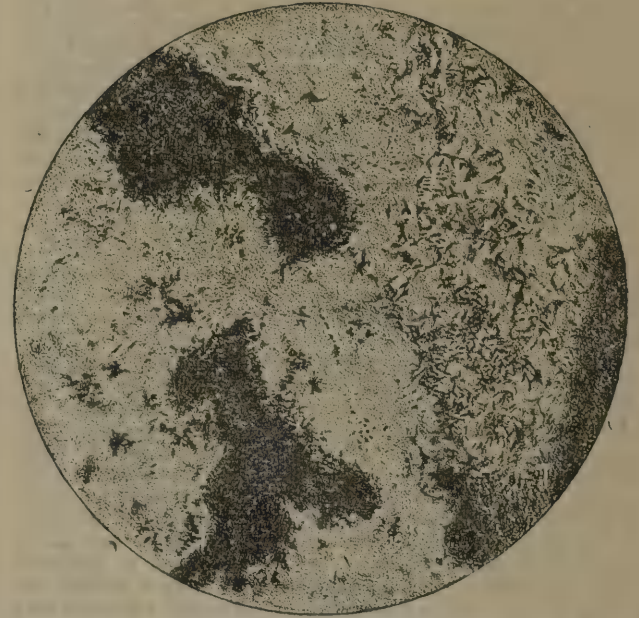


FIG. 2.—Pure Culture of Two Days' Growth of Löffler Bacilli. The thickened portions are large numbers of colonies.

This is a culture made from agar exposed over a sewer-trap, where the smell of escaping gas was perceptible. You can see different colonies of germs, some of which are the characteristic diphtheria bacilli, others cannot be readily differentiated, for I would add that there are dozens of micrococci and also bacilli which vary but little in size and shape, and can only be properly recognised after a thorough examination, including inoculation on animals, to find the virulence if present.

The streptococci caused death in one rabbit and also in a dog weighing five pounds after three days. A cat inoculated on the third day of the growth did not succumb. This latter experiment I might omit, owing to extreme difficulty in handling the animal, which I finally etherised and then inoculated. I concluded there might have been a slight immunity caused in this animal (cat) by the etherisation and consequent ether drunk.

In July, 1891, while taking a course in bacteriology at the Hygienic Institute at Berlin, we were taught an improved method for collecting germs found in the air in the halls and on the stairs and in the cellars. Several days previous to this we were working diligently with the anthrax bacillus and here and there a bacillus was found in some of the jars exposed. A warning given to us was that all members of the class using tobacco should not smoke their cigars and lay the stump on the table, for fear of carrying the anthrax bacilli from the cigar to the mouth.

Again, while I was experimenting with the Emmerich bacillus, or as it is sometimes called bacillus neapolitanus, we could occasionally find it in the air during the same day and on the following day, by exposing plates or glass jars which were previously carefully sterilised and then covered with a sensitive film of blood-serum (sterilised) or gelatine or agar-agar, or even sterilised potato which was properly peeled and cut in two. These were then exposed from morning to evening in a room, or closet, or cellar to be examined, and

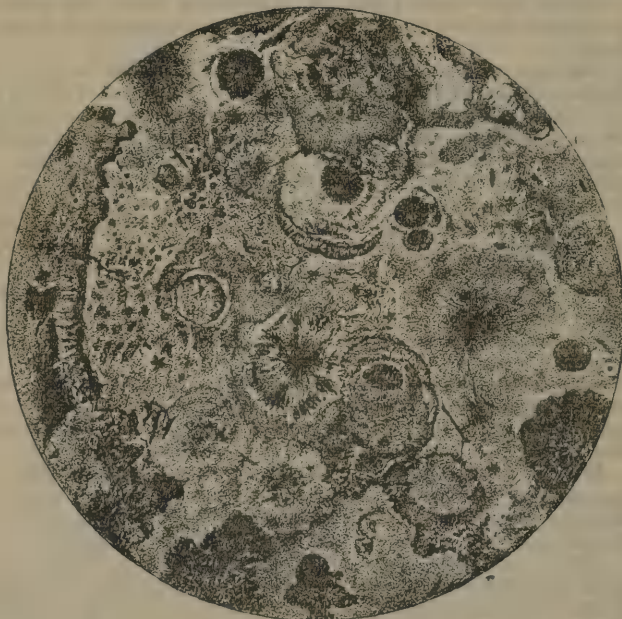


FIG. 1.—Eighteen Hours' Growth from which Various Micro-organisms were Obtained, Among them a Pure Culture of Typhoid Bacilli.

film on all sides of the tube. He then allows the suspected air to pass through, and in this way the germs are collected and examined, if present. For a more detailed description of the method, including experiments, I would beg to refer you to essays by Dr. S. Guttman, of Berlin, printed by Thieme, Leipsic.

In the same way as gelatine can be used we can use agar-agar as a nutrient film, and for my experiments I have preferred agar, although some experiments were equally successful with gelatine.

I covered the perforated funnel leading to the pipe with a

in this way conclusions reached as to purity or impurity of the air. To develop these micro-organisms, it is necessary to put these exposed jars, or plates, or tubes, into the thermostat, and allow them to grow about twenty-four hours in a temperature of 90 to 110° F. If our method was carefully applied, and our working utensils were sterile, we frequently got negative results. Of eighty-five experiments performed by me, forty-five must be excluded, owing to carelessness at the different houses and breakage of plates. Of the remaining forty, twelve yielded pathogenic bacteria, eight different micro-organisms (non-pathogenic), and twenty were negative. Although these germs will retain their vitality at lower temperatures, they develop spontaneously at higher temperatures, and it is interesting to note that bits of diphtheric membranes have been found alive six and seven months after being coughed.

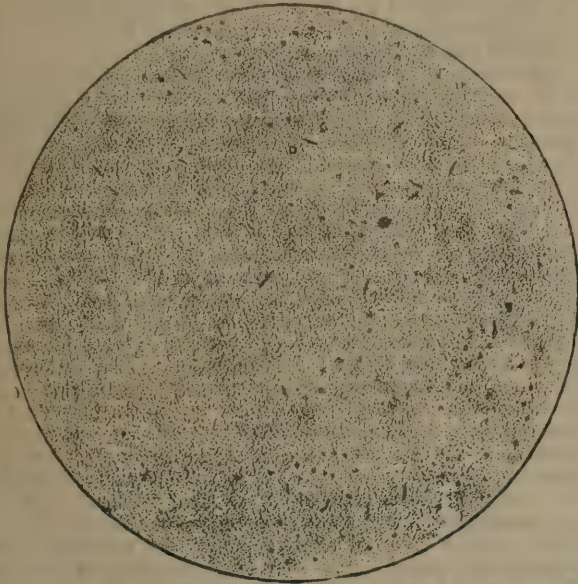


FIG. 3.—Micrococci and Bacilli from a Tenement Sewer Infected with Diphtheria.

Dampness and darkness seem to keep the germs alive and favour their development, and although some germs will die soon, it has been found that membranes kept in damp cloths and others enveloped in absorbent cotton seemed to live for months.

Cultures of diphtheria made in agar will keep alive in the laboratory for half a year and longer, yielding the germ peculiar to the growth only, *i.e.*, the Löffler bacillus.

Now, do micro-organisms develop different diseases under different conditions, *i.e.*, does a germ sometimes develop typhoid, the same germ diphtheria, or scarlatina, or measles? My answer is, Not any more than we should expect to have potatoes grow from pumpkin seeds.

Some time ago I inoculated the vagina of a guinea-pig with a virulent culture of diphtheria. After a day a large grayish-white membrane appeared, which on examination yielded Löffler bacilli.

I some time afterward performed tracheotomy in a large rabbit, and inoculated it with diphtheria. It promptly died in about twelve hours of paralysis, and the seat of inoculation yielded Löffler bacilli.

CONTROL EXPERIMENT.—I then performed tracheotomy on another rabbit and dressed the wound antiseptically. This latter rabbit got entirely well and was quite lively when I last saw it. In order to make comparative tests and examinations I resorted to the method used by Professor Koch and called control experiments. This consisted in examining a place where I was sure that sewerage was perfect, and examining in the same manner. I also examined the sewerage of the babies' wards in connection with the Post-Graduate Hospital buildings, and received negative results as to pathogenic bacteria.

Finally, it all resolves into a question of seed and soil, for if we have a child or an adult with a debilitated condition (sub-normal, let us call it), then the chances of infection of the soil by the seed are indeed great. Flies have long been known to be the carriers of infectious diseases and of infectious material, and recent experiments in Cholera Asiatica have shown that

flies can not only carry the cholera, spirillum but give pure cultures of living bacilli after five or six hours.¹

According to what I have said this evening and the proofs submitted, we are justified in accepting the following:—

That there seems to be a relationship existing between the infection of some cases of diphtheria on the one hand, and the escape of sewer-gas loaded with pathogenic micro-organisms on the other hand; that there are means at hand for examining these organisms, and that, although the method applied by me has been used by many others, there has appeared no record of the same in this country.

That cases of diphtheria developed by escaping moist sewer-gas containing Löffler bacilli seems to have been proven, I need only refer to the case I mentioned in detail, in which not only one child was infected, but families having lived there previously, two years before the other family the previous winter, had cases of diphtheria occur, one of them fatal.

It is also necessary for me to state that if a child or an adult has a weakened throat due to hypertrophied tonsils, previous attacks of diphtheria, catarrhal pharyngitis, nasopharyngeal catarrh, vegetations, or laryngitis, or the existence of anæmia, or a generally debilitated system, that such persons could more easily be infected owing to a previously weakened or diseased condition giving a better soil for the germ development.

RECAPITULATION.—1. In all, eighty-five different places or houses, having sinks with traps, were examined. Of these I will eliminate forty-five, owing to disasters in handling, or introduction of foreign material into a previously sterilised culture-medium. Forty examinations are entirely reliable, and I was greatly aided by competent people in avoiding breakage and introduction of filth. Twenty of these exposures were negative, twelve yielded pathogenic bacteria, eight more pathogenic micro-organisms, principally faeces bacilli, and numerous foreign bacilli, micrococci, and saprophytes, which could not be differentiated.

2. Some of the twelve specimens containing pathogenic bacteria yielded diphtheria bacilli (Klebs-Löffler), one of them typhoid bacilli in almost pure culture, associated faeces bacilli, and other cocci.

3. In three specimens I had streptococci, and in four specimens staphylococci, which could be easily distinguished and cultivated in the usual manner.

4. My animal experiments were very interesting and instructive, and aided me in determining the pathogenic condition of the bacilli, especially in one case which died of typical paralysis of legs.

LIST OF DEMONSTRATIONS.—1. Baginsky's thermostat.

2. Test-tubes containing cultures.

3. Large test-tube with gelatine coating, showing colonies.

4. Petri glass: *a*, sterilised gelatine; *b*, inoculate with suspected colonies; *c*, freeze the film; *d*, cultivate in thermostat.

5. Microphotographic preparations very carefully prepared under the tutorship and kind advice of Professor Oscar Mason, of Bellevue Hospital, who prepared all the negatives and positives and made the prints which I showed you this evening. With the aid of the stereopticon you can readily appreciate the smallest germ and some very indistinct colonies.

If tubercle bacilli can infect after sputum dries and liberates tubercle bacilli, does anyone doubt that a membrane expectorated on to bed-clothes, or on to the floor, or on the carpet, and then thrown into the sink, might not in a warm room be again liberated and inhaled? Nobody has ever seen a single tubercle bacillus in the air with the naked eye—nobody has ever seen a single Löffler bacillus. Then we are forced to resort to methods which might capture these germs and so form our own conclusions.

CYLINDROIDS OR SO-CALLED MUCOUS CASTS.

[Read before the Section in Genito-urinary Surgery of the New York Academy of Medicine, December 8th, 1892.]

By MORRIS MANGES, A.M., M.D., Physician to Outdoor Department, Mount Sinai Hospital, New York.

(Concluded.)

Composition.—The exact composition of casts being unknown, a corresponding degree of uncertainty must necessarily exist concerning the nature of the basement substance of cylindroids. Of casts, Knoll (21) says that their substance is identical with none of the known forms of albumen—as acid albumen, albumen, albumose, globulin, fibrin, mucin, or peptone. Rovida (2), who has paid more attention to this subject than anyone else, claimed that casts and cylindroids were

¹ See October number of Deutsche Med. Wochenschrift.

identical in composition. This is true if pseudo-cylindroids are not included; for, as already shown above, true and false cylindroids react differently to acetic acid, the former being rapidly dissolved, while of the latter some are unaffected, but others are swollen up and apparently disappear; however, they again become visible after staining.

This effectually disposes of the belief of many who have regarded *all* cylindroids as being simply shreds of mucus. Even admitting that renal cylindroids could consist of mucin, from what part of the kidney could the necessary mucin be obtained? The only rational source would be the pelvis; but in that case they would have a much less marked resemblance to true casts than they actually possess. Whatever cylindroids are formed there are undoubtedly belong to the false variety. Mucus cannot be secreted within the kidney, for it contains



FIG. 7.—False cylindroids from a case of gout and cystitis. Urine acid; specific gravity, 1.019; faint trace of albumen, large trace of mucin; free uric acid crystals very abundant. Epithelial cells of bladder and pus cells quite abundant. ($\times 400$.)

no muciparous glands. Millard and Danforth still adhere to the possibility of a catarrhal nephritis. The latter writer assumes that the necessary mucin is furnished by the tubal epithelium, most likely by that of the convoluted tubules. He maintains that, "under certain circumstances, the epithelial cells seem to undergo a change which is equivalent to the 'mucoid degeneration' of Ziegler, the protoplasm of the cell being transformed into a mucoid substance, which is afterward cast into the lumen of the tubule, there to aggregate itself with the similar product of neighbouring cells." Such views of pathology may be dismissed as antiquated, for very few writers any longer speak of a catarrhal nephritis. The only other possible explanation would be that mucin, being now recognised as a nucleo-albumen, might arise from changes in the renal cells. However, if so marked a lesion were present, we would have other manifestations of a well-marked nephritis.

Thus we may assume that renal cylindroids consist of some as yet unknown albuminoid substance. On the other hand, pseudo-cylindroids are probably formed from some variety of mucin.

Mode of Formation.—Of the three theories put forth to explain how casts are formed—viz. (a) by the liquefaction and metamorphosis of desquamated renal epithelium; (b) from secretory products of renal epithelial cells, the so-called vacuoles; (c) the coagulation of an albuminous transudate into the tubules—only the latter comes into play when considering the origin of renal cylindroids. Their very form speaks for the correctness of this assumption, for according to the amount of the transudate will the cylindroid assume the shape either of a thin, flat ribbon, or a hollow tube, or a solid cylinder. Originally the albuminous material is coagulated in straight lines; but the urine coming down from the glomerulus while they are still semi-solid, causes the various corkscrew twists, bends, and transverse folds. Their great length and the frequent occurrence of dichotomous division would seem to indicate that they are usually formed in the

straight tubules, although it is true that the branching of their extremities might also be explained by a subsequent splitting.

This view will also readily explain the bodies which are cast and cylindroid combined, by assuming either that through some obstruction the transudate was forced to fill out the entire tubule at some point, or that, although its amount was enough to form a cast in some portions, it did not suffice at other parts. The occurrence of snarls of interlacing cylindroids does not weaken this assumption, for Thomas (23) asserts that they may be formed by the meeting in the calyces of the streams from the various collecting tubules.

The occurrence of cylindroids in tubules with unaltered epithelium indicates either the coagulation of transuded albuminous fluids, or that the specimen was carried down from some point higher up. But to discuss this subject at greater lengths would only bring us back to the consideration of all the various theories on the formation of hyaline casts.

Pseudo-cylindroids are simply bands of mucin precipitated in the excretory ducts of the various glands of the urinary tract by the acid reaction of the urine.

Occurrence.—It is surprising how frequently these forms may be observed in the urine after we have once learned to recognise them. Where the urine has been mixed with various discharges—as in cystitis, leucorrhœa, or gonorrhœa, after coitus, after a hard passage, etc.—they may be readily discovered, as they are then quite abundant. They are also present in pyelitis, the various forms of nephritis, and congestion of the kidneys; consequently they are present in diphtheria, scarlet fever, and other exanthemata. I have recently even observed them in a case of typhus fever (see Fig. 6). They may occur alone or with casts, frequently alternating with the latter as the renal lesion abates in severity. These are least abundant in the chronic forms of nephritis. In normal urines they are by no means rare. Jaksch (8) (*loc. cit.*, p. 236) found cylindroids very frequently in the urine of children, with and without albumen, where renal disease could otherwise not be demonstrated. Among the non-albuminous urines they are especially liable to occur in jaundice, in concentrated and hyperacid specimens, and, finally, in subjects suffering from gouty manifestations and imperfect metabolism. It is just these cases which give us so much trouble in determining whether or no a trace of albumen might be present. These specimens are usually of a very high specific gravity (over 1.030), hyperacid, and contain a large quantity of urates; free crystals of uric acid and oxalate of lime are present when the urine is voided, or appear soon on standing. In these cases mucin is always present, often in considerable amounts. Hyaline casts, a moderate number of pus-cells, and at times even red blood-cells (where the pelvis of the kidney or other parts of the urinary tract have been irritated by sharp-pointed crystals), are by no means rare in such specimens. Many of these cases are put back and often rejected by life-insurance companies.

False cylindroids have absolutely no relation to albuminaria, but appear to accompany mucinuria. The renal varieties may be present with or without albumen. *The trace of albumen which is so frequently present in these cases is often probably due to the excess of mucin which is so common in these patients.* However, Le Nobel (22) has always found globulin in urines containing cylindroids.

The youngest age at which I have observed them was five years—in a little girl with psoriasis; her family history was decidedly gouty.

Diagnosis.—For the purpose of studying the general characteristics of cylindroids, the urine of any patients suffering from gonorrhœa offers a good field, since the forms here present are very easily recognised on account of the distinctness of the longitudinal striation, their greater refracting power, and their length. Moderate powers (300 to 400 diameters) are ample. The delicacy of the contours of these bodies requires that the illumination be not too strong; they may be very easily overlooked when gaslight is used. Staining with Lugol's iodine, picric acid, etc., is always of assistance.

Cylindroids are most readily found in freshly voided urine, especially if the minute flakes which are often inclosed in the mucus be examined. These flakes are very hard to find if the urine has been shaken up. Another means of detecting them is to look for the snarls already referred to.

The differential diagnosis is important. The greatest difficulty will be encountered in distinguishing the true from the false forms. The only absolute test is the solubility of the former in acetic acid, and the insolubility of the latter in the same reagent. However, the accuracy of this test is vitiated by the fact that some pseudo-cylindroids will swell up on the

addition of this reagent and apparently disappear. Staining with Lugol's solution will, however, show that the specimen can still be rendered visible. However, to carry out this test successfully requires not a little skill in microscopic technique

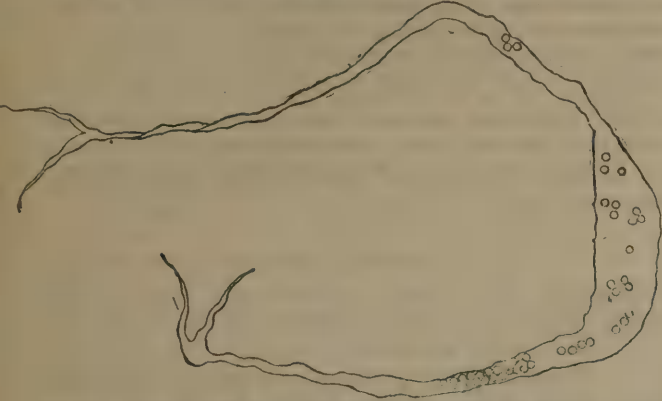


FIG. 8.—Very long false cylindroid containing blood-cells. Both extremities bifurcated. From concentrated acid urine with traces of albumen and mucin. ($\times 400$.)

to constantly keep the particular specimen in the field of the microscope.

The presence of albumen, casts, and renal epithelial cells would lead us to expect the renal forms, while an excess of mucin, the admixture with products from the bladder, prostate, urethra, vagina, and uterus, would indicate pseudo-cylindroids. In the latter, also, the striations are coarser, the refractive power is greater, the diameter varies more, the extremities are more frequently divided into more than two branches—in a word, the less the resemblance to true casts, the greater the probability that we are dealing with pseudo-cylindroids. Naturally, the differentiation is materially aided by the presence of adventitious products—viz., spermatozoa, epithelium of the lower urinary tract, etc.

In spite of all these distinctions, the differentiation between these two groups will not infrequently be attended with the greatest difficulties; and in some cases it is even impossible, especially where both forms are present.

From casts cylindroids may readily be distinguished by their length, irregular contours, twists, and above all, the longitudinal striations already referred to. Casts resemble a cylinder, while cylindroids are more band-like. Granular casts may be closely simulated where many of these characteristics have been obliterated by the presence of amorphous deposits. I have even seen true blood casts simulated by cylindroids bearing a large number of closely packed red blood-cells. In this connection it might be well for superficial observers to bear in mind how much renal casts differ from the usual typical drawings in most text-books, showing a cylinder with parallel sides and rounded extremities. Hyaline casts are quite frequently irregular in their contours, their sides often taper toward one extremity, bends are common, and Neubauer and Vogel even state (*loc. cit.*, ii. Theil, S. 155) that some may have bifurcated extremities.

I have already spoken of the forms which are at once cast and cylindroid—i.e., either the casts with spiral and tapering extremities, which are quite common, or the very rare forms in which cylindroids are inclosed in casts.

Significance.—Having thus shown the necessity of regarding these bodies as something more than mucous casts, and having also proved the existence of both true and false cylindroids, the question naturally arises, What is their significance and what prognostic conclusions may be drawn from them?

The pseudo-cylindroids, as such, may be dismissed without another word, as their significance is limited to simply recognising them as such. Whatever bearings these forms have in diagnosis is merely due to the difficulty which may be encountered in absolutely distinguishing them from the true renal varieties.

Leube (10) (*loc. cit.*, p. 447) asserts that in his opinion there is no reason for specially distinguishing cylindroids from ordinary casts, especially as the latter so frequently have lateral indentations and axial twists. Rosenstein (11) (*loc. cit.*, p. 45) denies the right of attributing to cylindroids a special importance which renders their distinction from casts necessary. Fürbringer (9) (*loc. cit.*, p. 36) coincides with the latter.

Thomas (23) believes that where cylindroids are replaced by casts an exacerbation of the nephritis may be inferred; and, *vice versa*, cylindroids take the place of casts when the renal

process abates. He also assumes that cylindroids are present where the quantity of albumen is very minute, and that they may even be the only signs of a mild nephritis. The latter may frequently be due to the excretion of infectious elements; in some cases the process resolves; in others it goes on to a nephritis. He suggests that bacterial influences may be discovered in many other cases where cylindroids occur.

The views of von Török and Pollak, Tyson, and others have already been stated.

Danforth, in addition to what has already been quoted of his contention that "mucin casts" establish the diagnosis of catarrhal nephritis, also maintains that these bodies are of great importance in the early recognition of interstitial nephritis.

My own belief is that if we can be absolutely sure that we are dealing with true renal cylindroids, their significance would be about the same as that of hyaline casts. But the value of such inferences is materially lessened by the great difficulties which often attend this differentiation. Not infrequently I have found it impossible. So experienced an observer as Peyer admit the same. Therefore, to attribute any absolutely diagnostic significance to cylindroids is not justified, as these doubtful cases usually occur where our other means of diagnosing nephritis also leave us in the lurch.



FIG. 9.—False (spermatic) cylindroids found in urine after passage of hard fæces. ($\times 300$.)

Such a conclusion once more reminds us that a diagnosis of nephritis ought not to be made from an examination of the urine alone; but that all the other organs should be interrogated before making absolute statements as to the existence of renal disease.

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

MAY 15th, 1893.

DR. I. TELYAFUS, of Tiflis, has recently published a brochure embodying his views as to the most efficient means of strangling cholera in its Indian home, and of thus freeing Europe from the constant menace of its periodical excursions. The habitat of the cholera bacillus is, he says, the delta of the Ganges, a low-lying area of some 7,500 square miles, intersected by the many mouths of the Ganges and Brahmapootra rivers. The soil of the delta is very moist, and contains the putrefying remains of many forms of animal and plant life. Cholera has raged here endemically from time immemorial, and every now and then, after unusually heavy rains, or from other ill-understood causes, it emerges thence and invades one or more of the neighbouring provinces, or spreads as a pandemic over the entire world. There have been four such general invasions, and we are now passing through the fifth.

Proust, in his work on hygiene, regards as Utopian any attempt to exterminate the germs of cholera in India, but with this pessimistic view Dr. Telyafus takes exception. He says that the plague has been stamped out in the Nile delta, and he thinks that similar or more energetic measures would be equally effectual on the banks of the Ganges. Formerly the fellaheen of Egypt interred their dead on the borders of the river Nile, and the bodies were then washed out into the stream during the annual overflow of the river, and were carried down to spread disease throughout the delta. Since an end has been put to this custom the plague no longer harasses the country.

It would doubtless be difficult, if not impossible, to restrain the natives of India, inhabiting the region of the Ganges, from casting their dead into the waters of the sacred stream; but the author thinks this difficulty might be obviated by compelling the people to cremate their dead, and then throw the ashes on to the bosom of the river. He would also endeavour to improve the sanitary condition of the delta by planting extensive eucalyptus groves, as has been done on a large scale in Algiers. In the latter country there were, a comparatively few years ago, large areas of almost

uninhabitable marshes which are now settled and extensively cultivated by a numerous and industrious population. The change has been effected by drainage and the planting of eucalyptus trees. The same measures, the author believes, would result in transforming the delta of the Ganges into a salubrious and rich agricultural section. The expense of such works would, of course, be enormous, but this would no doubt be covered to a great extent by a vastly increased production, and would be more than compensated for by the saving of thousands of valuable lives in this region alone every year.

THE term amusia, recently introduced into medical nomenclature, may be said to denote with regard to the musical faculty about what the word aphasia, in its most comprehensive use, imports with regard to the faculty of speech. Some interesting examples of loss or impairment of the ability to proceed or to comprehend music are on record, and a condensed account of the more important observations bearing on the subject is given in a *revue générale*, by Dr. Paul Blocq, published in the *Gazette Hebdomadaire de Médecine et de Chirurgie* for February 25th.

Aphasia is not always accompanied by amusia, as was mentioned by Bouillaud so long ago as in 1865. There is a well-known story of a certain aphemic who sang the *Marseillaise* with the only articular sound that he could make, and Bernard speaks of an aphasic who sang that melody and the *Parisienne* with the substitution of *tan, tan, tan* for their proper words. Proust had a patient who could write music, although incapable of reading it. A still more curious case was recorded by Grasset in 1878, that of an officer who, while he could articulate only *pard* and *b* in his attempts to speak, could sing the words of the first verse of the *Marseillaise* with the utmost correctness. Charcot's authority is given to the story of a trombone-player who lost his capability of performing on the instrument, although he had preserved all his other faculties.

Blocq credits Knoblauch with having established the autonomy of such a pathological state as amusia in 1888. In 1891 Wallaschek made an important classification of the varieties of amusia, distinguishing motor amusia, in which the patient comprehends music, but has lost the power of singing; sensory amusia, in which the subject can no longer distinguish sounds; paramusia, in which the subject sings, but with mistakes in time and note; musical agraphia, or loss of the power to write notes; musical alexia, loss of the ability to read music; and musical amimia, loss of the power of playing on an instrument. Blocq, like Onanoff, adopts an analogous classification, distinguishing a receptive, or sensory, amusia and a motor, or expressional, amusia, the former including auditory amusia and musical alexia, and the latter comprising true amusia (loss of the power of singing), musical amimia, and musical agraphia. True sensory amusia may be termed musical deafness, and musical alexia may be called musical blindness.

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NEWS AND NOTES.

AN interesting case was brought up in an Austrian Court recently *in re* Drs. Jantsch and Popper. These gentlemen had been called to the bedside of a child by the father; both appear to have agreed that the case was one of measles. Popper appears from the evidence produced in Court to have been first in charge, Jantsch a little later; but Jantsch, considering himself master of the position, wrote a prescription and gave directions, while Popper remonstrated against the conduct as unprofessional, which led to a scene at the bedside, and strong language on both sides. The judge, being rather perplexed how either of them should conduct themselves, proposed, not without excuse, that they "should apologise to each other and behave as gentlemen in the future."

PRURIGO SECANDI, or perhaps we should say *cacoethes secandi*, prevails in France as well as elsewhere. Professor Léon Le Fort, Professor Verneuil, Professor Duplay, and Professor Tillaux have been asked by a public journal for their opinions on the operative mania (*furie opératoire*) said to be prevalent at present. Professor Le Fort says it is much more widespread in France than in other countries; and in a long letter he protests against the custom among the young French surgeons, in order to bring their names before the public, "to seek out some operation unknown in France, then seek out a victim on whom they can perform it, in order to report it before a medical society, and perhaps also show the patient." Then, says M. Le Fort, they take up the operation as a speciality, perform it on a hundred or two hundred patients, and thus gain a reputation. Professor Verneuil protests against the abuse of operations in general, and especially of gynecological operations. He deplores the *prurigo secandi* with which so many of the French surgeons are attacked. Professor Duplay and Professor Tillaux express the same opinions.

SIMILARLY, the removal of the ovaries from insane women has caused a rich discussion in Pennsylvania. It seems that the gynecologists picked out some fifty from a public institution as fit subjects for such operation. Some operations were done, when the controlling board stopped the series, and from this grew the discussion. At this distance it is impossible to fairly judge in the matter. If ovaries are removed from insane women for the same reason as from the sane, the insane have no occasion for complaint. If, however, the ovaries are removed for the cure of insanity in cases where they would not be removed from the sane, then there is occasion for it. The lines are not defined with great clearness, that determine the removal of the tubes and ovaries. Generally it is admitted that such an operation is admissible in cases having pus in the tubes and ovaries, and other organic disease, though all are not agreed on this point. The controversy is memorable as having elicited from the *American Lancet* the tasteful and seemly comment that when women physicians become more abundant it will not be surprising to hear that they are removing testicles by the hundreds, and exhibiting them at medical societies by the painful.

A LADY practitioner in Edinburgh has applied for admission into one of the medical societies there. As at the time when the society was founded the law-makers had no thought of a doctor in petticoats, there are no rules against one being admitted, provided she pass the ordeal of the ballot. A special law will probably be rushed through before she can cross the threshold or undergo the ignominy of being blackballed. There seems to be a general feeling against admitting ladies. Let them have a society of their own, says the ungallant *Medical Press*.

THE most ideally sterile spot in the universe is undoubtedly the moon, but on this particular planet the Spitzbergen group of islands, in the Arctic regions, are found to be a close second. During a recent sojourn there M. Coutsaud took the opportunity of studying the bacteriological peculiarities of these ice-bound spots. Analysis of the air, water, and soil of Spitzbergen brought to light the extraordinary poverty of these regions in bacteria. While, according to Miquel, the air of the streets of Paris contains on an average 51,000 bacteria, that of the Arctic Sea contains only three, per respective cubic metre. As to the water of Spitzbergen, not only is it devoid of any pathogenic micro-organisms whatever, but all bacilli are absent. In the water of the island of Jan Mayen, however, there were

discovered the bacterium termo and a few short and mobile bacilli. The bacillus subtilis, so commonly met with in the different countries of Europe, was indiscoverable in the soil of those regions. At Jan Mayen there was found in abundance a leptothrix composed of long filaments, irregularly twisted, about one μ in diameter, producing elliptical and highly refracting spores. This species grows on gelatine into dense colonies, which possess no liquefying properties, but develop during growth a characteristic brown coloration.

AN esteemed illustrated weekly has, says the New York *Medical Record*, published the following humorous paragraph: "Have you heard about Dr. Bolus? He has challenged Dr. Hokus to a deadly duel." "Has he? And what weapons has Dr. Hokus named?" "Prescriptions." The deadly character of prescriptions was first noted and treated of in the same laughter-making way as above by Nicarchus, the Greek, four hundred years before Christ. It can hardly be doubted that Plato and Socrates were very much amused over it at about this time, when the joke may be said to have been really current and in the air. One can easily imagine how annoyed Hippocrates must have been at the guying he received, for that learned gentleman seemed to have lacked a sense of humour, and the prescriptions that he gave were carefully gathered and cautiously doled out. A few hundred years after his time, Juvenal was unable to refrain from reviving the pleasant facetiae of Nicarchus and Martial hit it off still better in his very stinging way. There is evidence that Galen must have laughed uneasily at this time. A full account of the historic course of the Nicharchian jest over the deadliness of prescriptions would lead us to annotations upon the lives and writings of Molière, Pascal, Montaigne, Addison, Joseph Miller, and other ancient and distinguished litterateurs and wits, upon whom our modern contemporary so felicitously draws. We can extend hearty congratulations that Nicarchus has reached the office of a modern New York humorous editor. There is nothing which lives like a good joke. The liver-jostling wit, for example, which stands quoted at the beginning of these remarks, is exactly 2,293 years old, and yet here it is making laughter to-day as it has been doing in the echoing corridors of the past centuries. Great is the power of a humorous and inventive mind! It is to be observed that the prescription joke as cited above is not exactly as given originally B.C. 400 by Nicarchus. In fact, while the essential spirit of the wit is retained, the form is a little patched and amended; we might say doctored, perhaps; for the true function of the funny paragraph of the day is to doctor old jokes, changing their sturdy senescence into a spirited and contemporaneously interesting juvenility. There may yet be in the higher journalism of the future a degree conferred—*Jocorum Doctor*; and we know where the honour should be first bestowed. If the present generation of humorous paragraphers who are working on the prescription at set intervals were better acquainted with history they would know that on one occasion a duello did occur in which the prescription was the weapon. It was some hundred years ago, when gentlemen of all persuasions were more disposed than now to personal controversies. Dr. Wynter and Dr. Cheyne were the contestants. The provocation we do not remember, but the duellists were rival practitioners, and no doubt there had occurred plenty of good reasons for mutual hard feeling. Dr. Wynter fired the first shot with the following—we regret we cannot, for want of space, give all his verses:

Suppose we own that milk is good,
And say the same of grass;
The one for babes is only food,
The other for an ass.

Doctor, one new prescription try
(A friend's advice forgive)—
Eat grass, reduce thyself, and die,
Thy patients then may live.

Dr. Cheyne, who was somewhat obese, but lacked not in wit, replied:

My system, doctor, is my own,
No tutor I pretend;
My blunders hunt myself alone,
But yours your dearest friend.

I can't your kind prescription try,
But heartily forgive;
'Tis natural you should wish me die
That you yourself may live.

The versification in the penultimate line is sadly to seek!

MEDICAL LITERATURE.—IV.

A BOOK OF THE MONTH.

Embryology of Man and Mammals. By DR. OSCAR HERTWIG. 339 Figures and 2 Coloured Plates. Price 21s. (London: Swan Sonnenschein and Co.)

[Specially reviewed by PERCY JAMES EDMUNDS, B.Sc. Lond., &c.]

THE third German edition of Dr. Oscar Hertwig's "Text-Book of the Embryology of Man and Mammals" has just been translated into English by Professor Mark of the Harvard University. The work is published by Sonnenschein and Co., and contains over 600 pages and over 300 engravings, and forms the most recent and probably the best text-book on the subject yet published in our language. This youngest and most difficult branch of biological science is presented to the student in a consecutive and lucid manner by the author. At every step we are confronted with the two great obstacles that bar the progress of all sciences, viz., the difficulty of observing what are the facts, and the difficulty of interpreting the facts that are found. In embryology especially do we meet with conflicting statements of fact and conflicting interpretations thereof—and this apart altogether from the circumstance that the rationale of the whole process of development, the "reason why" of development at all, is as much a mystery to the embryologist as to anybody else, perhaps more so. We are glad, however, to record our opinion that the volume before us is a clear and interesting statement of the science from the author's point of view, and yet contains a just and accurate explanation of the views of others. The summaries at the end of each main section prevent the student getting entangled too much in the complexities of the subject; whilst the historical references are full of interesting though too often exploded theories, and serve as a caution against mere speculation and assumption.

In Part I. the author commences with a detailed description of the egg-cell, and classifies eggs, firstly into simple and compound, and secondly according to the manner in which the deutoplasm (or food-stuff) is distributed. The human ovum is a simple egg, and its deutoplasm is small in amount and uniformly distributed over the protoplasm. After a description of the origin and structure of the spermatozoon, the author gives a careful account of the formation of the nuclear spindle in the egg-cell, and of the extrusion of the polar cell, whereby the female pronucleus is left behind; then follows the process of fertilisation, during which the head of the spermatozoon forms itself into the male pronucleus within the egg-cell, the male and female pronuclei fuse together, and the egg-cell now becomes the embryo. Having next given a general description of the process of cleavage, and of the general principles which underlie the progress of an embryo, from homogeneity to heterogeneity of structure, viz., invagination, evagination, separation and fusion of cell-layers, the author follows up the morphological history of the embryo through the blastula and gastrula stages, and thus completes the formation of the two primary germ-layers—epiblast and hypoblast. Thence we come to the formation of the mesoblast and body-cavity, to the development of the primitive segments, of connective tissue and blood, the establishment of the external form of the body, and to the formation of the foetal membranes.

Part II. traces out the development of the different organs of the body from the germ-layers above mentioned. The alimentary canal and its appendages arising from the inner germ-layer—the voluntary muscles, urinary and sexual organs from the middle layer, the nervous system and skin from the outer germ-layer, and the blood vessels and skeleton from the intermediate layer, are each dealt with successively in detail.

The most difficult portion of the work for the student to follow is undoubtedly the latter portion of the first part.

Here the author enters upon very debateable ground. We refer more especially to his treatment of the origin of the connective tissues, which he traces from what is called the "mesenchyme," or "intermediate layer," a fourth layer not as yet universally acknowledged. Up to the formation of the germ-layers and the body-cavity, however, all is pretty plain sailing; and it may fairly be asserted that all who profess to scientific knowledge should be well acquainted with the primary facts of development up to this point. So also the second part of this volume, dealing with the development of special organs, and throwing light as it does upon congenital deformities and many interesting facts in adult anatomy, is of essential practical value to the medical man; and we can cordially recommend Dr. Hertwig's treatment of the subject for careful study. As a work of translation also

we can find nothing to complain of, the English rendering being clear and accurate throughout.

We may conclude by referring shortly to a subject of much interest to the general reader, namely, the history of theories of development. We read, on page 23, that "in the last century the most distinguished anatomists and physiologists were of opinion that eggs agreed in their structure in every particular with the grown-up organism; and, therefore, that they possessed from the beginning the same organs in the same position and connection as the grown-up organism, only in an extraordinarily diminutive and transparent condition." This *preformation*-theory of Haller was backed up by an equally amusing one; for we read further on that "it follows that in any germ the germs of all subsequent offspring must be included. In the extension of this *box-within-box*-doctrine, its expounders went so far as to compute how many human germs at the least were concentrated in the ovaries of Mother Eve, and arrived at the number 200,000 millions." How utterly and hopelessly wrong, and yet how reasonable at first sight was this theory! It reminds us of a long and ridiculous argument we once held with a non-scientific gentleman (it whiled away the time on a P. and O. steamer in mid-ocean), who asserted that there must be whisky in potatoes, because whisky was made from potatoes. If, at the close of the discussion, a ballot of opinion had been taken as to who had got the best of it, we firmly believe that the majority would have voted for the whisky-in-potatoes theory—a clear proof that in science, as well as politics, majorities may be utterly wrong. And yet, in the matter of theories of development, though we may smile at our ancestors, what have we to offer in their place? The answer is, none. The ova of fishes are fertilised in the water, and undergo their full development far from any influence of either parent. Thus no mechanical or chemical theory, implying the continued influence of the parent, can be admitted. In fact the parent is but the soil in which the embryo grows; and the latter is, so to speak, as much a parasite as it can well be, from the moment of fertilisation. The single cell divides, and redivides; its parts undergo arrangement and re-arrangement, while specialisation of function follows; and in all this the cell seems governed by a "psychical-tendency" or a "will-power," or a "vital spirit" (call it what we like) from the beginning. Long before the differentiation of a visible nervous system, we see activity of growth in an orderly manner with unity of design proceeding to a definite consummation. The single embryonic cell possesses at the start something (?) which baffles alike our perceptions and our logic. But if we exclude (as we obviously can), a theory of *mechanical* preformation, how can we refuse to admit a theory of *psychical* preformation?

BOOKS.

[Works for notice under this heading should be addressed to the Editor at 46, Holborn Viaduct, not later than the 8th of the month. Publishers will assist the Editor and reviewers by stating the price of every publication forwarded.]

DR. WILLIAM ODELL, of Torquay, has brought together in his interesting pamphlet, "Recreation" (Torquay: Andrew Iredale. London: Simpkin, Marshall, Hamilton, Kent & Co., Limited. 1893. Pp. 44. 1s.), a considerable bulk of interesting opinions on the importance of this factor in healthy living. The brochure appears to be a reprint from an address read before the Torquay Natural History Society last December, and among its most valuable features are letters from the head-masters of various public schools, who have been industriously questioned as well on the athletic question at large as on the relation of good school work to vigorous out-door play. Our own opinion has always been while *mens sana* is, if not wholly dependent upon, at least largely indebted to its environment in *corpore sano*, the highest intellectual distinction will seldom be found conjoined with athletic supremacy, though there is no reason why men—and boys—should not attain the highest ranks in either class of pursuits compatibly with a respectable competency in the remaining class, and this seems to be exactly the experience of the present head-master of Harrow, who writes to Dr. Odell:

"I do not think I ought to say that the athletic boys of the school are generally the most distinguished in their work, but they are certainly not idle boys, and quite enough of them are intellectually distinguished to justify the statement that there is no such thing as a necessary severance between proficiency in games and proficiency in work."

The Rev. G. C. Bell, headmaster of Marlborough College, expresses a similar experience :

"It is not common," he says, "to find exceptional excellence in athletics combined with the highest kind of brain work."

But the main tendency of the pamphlet is to hold a brief for athletics in all reasonable forms, and, always remembering that it is a brief, the work could not well have been more reasonably and more interestingly done.

GLYCERINE IN CONSTIPATION.

By JAMES D. STAPLE, M.R.C.S.Eng., L.S.A.Lond., late House Surgeon and Visiting Surgeon to the Stockport Infirmary, &c.

[Reprinted from the LANCET, Feb. 25th, 1893.]

DURING my residence at the Stockport Infirmary I gave glycerine enemata in over a hundred cases, and on referring to my notes I find that the quantity injected was one drachm for children and two drachms for adults, the syringe used being the special one sold by instrument makers for the injection of glycerine. The bowels acted generally within fifteen minutes, in some rare cases half an hour elapsed, and on two occasions the injections had to be repeated. Since then I have discontinued the enemata, and now I administer the drug by means of a suppository or "Glycone," which can be obtained from any chemist at a small cost.¹ The suppositories vary in strength, I believe, but some contain about 95 per cent. of glycerine, and the results are the same as when the glycerine is given by enemata. These little suppositories can be most easily and quite painlessly introduced, and the patients can themselves insert them. If one suppository fails to act in from five to twenty minutes, which is a rare occurrence, the introduction of a second will soon have the desired effect. Some of the advantages of glycerine administered by this method are absence of pain, ease of administration, rapidity of action, and absence of griping. Glycerine suppositories are particularly useful in cases where an aperient by the mouth is not advisable. In midwifery practice, too, they are very useful for rapidly emptying the bowels. In the chronic obstruction of old people, caused by hardened feces in the lower bowel, glycerine suppositories are especially useful.

City Road, Bristol.

AMERICAN OPINION.

INTERNAL URETHROTOMY:

AN ABSTRACT OF THE RESULTS OF THIRTY-SIX OPERATIONS.

By B. MERRILL RICKETTS, M.D., Ph.B., Cincinnati, Ohio.

THE operation of itself I consider a simple one, and if sepsis is guarded against, febrile disturbance will not occur. The complications that arose in these thirty-six cases were:—

1. Urethral fever.
2. Orchitis.
3. Perforation into the rectum.

Of the first, I have had three cases where the temperature reached 102 degrees, and which subsided within seventy-two hours. We know that the simple introduction of a catheter or sound, hard or soft, will cause a rise in temperature which is usually of short duration, and we have reason to believe that this rise of temperature is due to septicæmia.

In the second-class—orchitis—it is interesting to note that inflammation of the testicle did not occur until after the eleventh day in one, thirteenth in another, and fourteenth in another. The eleventh began while the patient was still confined to his room. The thirteenth began four days after the patient had returned to his duties, which were those of a commercial traveller. This great length of time, I believe, will exclude the primary operation as being the cause of the orchitis.

In two of the cases—the first and the second—there was no introduction of the sound after the withdrawal of the urethrotome. In the third, however, the sound was introduced every third day; possibly the introduction of the sound in this case caused the orchitis.

In the third—perforation into the rectum—I feel that there is a ray of hope of my not being responsible when we consider the possibility of there having existed a recto-urethral fistula. The urethra was serpentine, and only admitted a No. 17 French sound with great difficulty. I advised an internal urethrotomy, and my attempt to do the operation under the influence of

chloroform was thwarted. The patient was allowed to come from under the influence of the chloroform, and informed of the difficulty. On the next day I was successful, but before adjusting the instrument with my finger in the rectum I found that its point and my finger came together. The bladder was entered without difficulty, the operation done, and a No. 30 French sound introduced with ease, and the patient returned to his work, that of a book-keeper, on the following Saturday

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

OTITIS MEDIA is discussed from its surgical aspects by Dr. Jack in the *Boston Medical and Surgical Journal*. He concludes: "1. The removal of the drum membrane and ossicles is attended with little annoyance to the patient, proof of which is sufficient to warrant the performance of the operation as the only means of cure in many cases. 2. The operation often produces marked improvement of the hearing. 3. Satisfactory results may be expected towards the relief of tinnitus and vertigo. 4. The results of the operation seem to be permanent." Excision of the Ossicula is not always free from danger. Wurdemann reports a case in which vertigo and complete deafness followed, and was attributed to the hæmorrhage into the labyrinth. In speaking of a case in which remarkable improvement of hearing followed removal of the stapes, Dr. Jack says: "Not only is the simple removal of the stapes much better in its results than the removal of the two large bonelets only, as shown by the operations already performed, but on the ground of conservative surgery it is also much to be preferred. It produces greater improvement in the hearing, and according to my experience up to the present, there has been no inflammatory reaction whatever, or any other bad results."

FOR LARYNGISMUS STRIDULUS, OR CROUP:—

R Chloroform	...	...	...	...	gtt. v.-x.
Water	...	...	...	...	3 vij.
Glycerine	...	...	...	...	3 j.

M. Sig.: A teaspoonful every thirty minutes until the patient is relieved.

—*Therapeutic Gazette*.

DETECTION OF FOREIGN BODIES IN THE CORNEA.—Dr. Jackson states that an aid to the detection of foreign bodies in the cornea is the use of a solution of fluorescein. A good solution consists of:

R Fluorescein	...	...	...	...	gr. j.
Sodium carbonate	...	...	...	...	gr. ij.
Distilled water	...	...	...	...	5 j.

A drop of this is placed on the suspected cornea, and after two or three minutes the excess is allowed to be washed away by the tears. It is then found that while on the uninjured cornea not the slightest effect has been produced, the corneal tissue in the neighbourhood of any recent abrasion has been stained a light green. This discoloration directs attention to the locality of the injury, and the stained tissue furnishes a background against which any foreign body of dark colour is readily seen.—*Medical Times and Register*.

SUBCONJUNCTIVAL APPLICATION OF COCAINE FOR EYE OPERATIONS is discussed by Dr. Kaller, who says: "First I instil a few drops of a four per cent. solution and wait several minutes, after which the instillation is repeated. Now I insert the speculum, and, by means of a sterilised hypodermic syringe, inject a few drops of a two per cent. solution of cocaine under the conjunctiva, next to that part of the cornea where I intend to make the section. This will be the upper part in most cases. The solution has been sterilised previously by boiling it, and the hypodermic syringe by rinsing with alcohol and then with a two per cent. carbolic acid solution. After the injection the speculum is removed, and one has to wait from five to ten minutes for the artificial œdema at the place of injection to subside, as it possibly would be in the way of the knife. It is slow to disappear, gentle rubbing will hasten it. The anaesthesia thus attained is complete, and will contribute to diminish that percentage of prolapse of the iris that still adheres to our statistics of cataract extraction."—*New York Medical Journal*.

I HAVE been in the habit of prescribing Lactopeptine for some years, and I can only say that the more I use it the more satisfied I am that it is one of the most beneficial medicines at present extant for the treatment of dyspepsia.

Its remedial effects in chronic indigestion are most marked. Some twelve months since I ordered it in a case of no less than fourteen years' standing; my patient, after taking some

¹ GLYCONES (LILLY).—In waterproof non-metallic covering. Infant or adult sizes. Manufactured by Eli Lilly and Co., of Indianapolis, U.S. British Depot, 46, Holborn Viaduct, London. Price (either size), 2s. 6d. per box of one dozen. To the Medical Profession, 1s. 9d.; post free, 1s. 11d.—Ed., *M. R.*

24-grain powders, expressed herself as feeling quite another being than she had felt for the above-mentioned period, and expressed a strong desire for me to order her a bottle or two of the powder.

R. E. HAYES, M.R.C.S., L.R.C.P., &c.
Lisburn, co. Antrim, Ireland.

CACTUS IN HEART DISEASE.—In many functional complaints of the heart cactus is a valuable remedy. In the palpitations of dyspepsia, sexual exhaustion, and excessive tobacco smoking, the tincture in two or three minim doses three or four times a day seldom fails to give relief. According to Dr. Percy Wilde, the use of cactus is indicated where there is over-action of the heart with throbbing in the carotids. In Graves's Disease cactus is a useful palliative; in the milder forms of Angina Pectoris it has been found most beneficial. Cactus is said to strengthen the ventricular systole, and also to shorten the diastole; thus it is a true heart tonic.

Whitby.

A. C. DUTT, M.B. Cantab.

SWEDISH TURNIPS have been found by Von Baracz well adapted to replace Senn's decalcified bone plates. They are hardened by being kept for four days in a one per cent. carbolic acid solution. Experiments showed them to be completely digested in fifteen days, and in one anastomotic operation they proved successful.—*Centralb. für Chir.*

CINNAMIC ACID in the form of an emulsion, or in the following solution, for hypodermic use, is being tried by Lauderer and others as an anti-tubercular agent:—

Cinnamic acid	...	...	...	1 part.
Cocaine hydrochlorate	...	...	...	1 part.
Alcohol	...	...	...	20 parts.

In lupus and surgical tuberculosis one or two drops at a point are injected into the patch or nodule, until about ten drops have penetrated the tissues. In forty-five cases of surgical tuberculosis, Lauderer secured 68 per cent. of cures and 15.5 per cent. of cases improved. The acid appears to cause resolution in the tubercular inflammation.

ABDOMINAL PALPATION alone, Guyon says, does not permit a diagnosis of tumour within the bladder, and anything thus felt is to be regarded as perivesicular. Rectal touch combined with pressure in the hypogastrium, when the bladder is completely empty, may teach much regarding not only the presence but the nature of a neoplasm.

CANCER OF THE STOMACH has been thought to have its presence indicated, if in the diagnostic test no free hydrochloric was found in the stomach, and this method has been employed in the Massachusetts General Hospital, the New York Cancer Hospital, and other institutions, but with no very constantly positive results. Ewald (*Berl. klin. Woch.*) has just shown that the absence of hydrochloric acid is not only noted in gastric carcinoma but also in chronic catarrh followed by atrophy of the mucous membrane, and in severe nervous depression. Old persons who have had much dyspepsia show atrophy of the lining membrane of the stomach, and there cancer may exist for a long time before it is suspected.

BORATED GLYCERINE is considered by Dr. Bryson superior to any fatty substance as a lubricant for urethral instruments, being readily and thoroughly washed off, and showing by an opacity when it is no longer aseptic. Thus the dangers from urethral fever are lessened.

CORRESPONDENCE.

To the Editor of MEDICAL REPRINTS.

SIR,—On looking through the April number of your interesting periodical, I was struck with the fact that the artist of "a scene in the operating room" had depicted quite a crowd of spectators watching the otherwise tame and prosy proceeding of placing the final bandage in position after some operation upon the patient's left leg or foot. Such unwonted interest used not to be shown in my student days, and when I pointed this out to an especially acute nursing-pupil of the St. John Ambulance Association, she at once remarked that it "was no wonder that the group was staring. The operator was first of all bandaging from without inwards and secondly was bandaging from above downwards, reversing over the sharp edge of the tibia and not on the fleshy cushion of muscle. Moreover, the operator was standing with his back to the patient instead of having the limb directly in front of him, upsetting all the canons of good bandaging." I was so struck with these observations that I wonder if any others have noticed the errors of the artist.—Yours faithfully,

J. C. W.

A CHINAMAN'S GRATITUDE.

DR. HORACE RANDLE, of the Tungshin Hospital, Chefoo, North China, relates in *Medical Missions* an instance of the profound gratitude of the Chinese for successful medical treatment. One of the magnates of the place, named Wu, had been an enemy of the mission for several years, even advocating violence in order to expel the foreigners. But last October a change came over the man, in consequence of a serious and protracted illness. He was afflicted with an unusually large carbuncle upon his back, and all the native treatment he endured simply made matters worse and brought him down almost to death's door. Although he had repeatedly refused to consult a foreign doctor, pain and suffering finally led him to reluctantly admit Dr. Randle. That gentleman found the region of the left scapular occupied by a gangrenous mass, and the patient's general condition at a low ebb. The open surface was properly cleansed, then poulticed and dressed for a few days, suitable internal medication was furnished, and the patient was put on the road to recovery. Convalescence was slow, though steady. A change from enmity to friendship was likewise gradually effected. The patient was first shamed out of his hatred, and then, seeing the physician's manifest devotion and laborious attentions, became as emphatically grateful as he had before been antagonistic. When he had fully recovered, Mr. Wu caused a tablet to be engraved, painted blue, with gilded and carved characters expressive of his unstinted gratitude. Then a procession of his relatives and friends was formed at the patient's house, and proceeded to that of the physician, followed by two coolies bearing the tablet. The townspeople crowded after. When the destination was reached, a speech of presentation was made, and the tablet was nailed up over the front door by two carpenters who had been bidden to come for that purpose. Then an interchange of compliments took place. The inscription on the tablet was as follows:

"A Heart like Hsi-wen's.

"In early times, Doctor Fan Hsi-wen was a skilful and benevolent doctor whose heart constantly went out in healing and saving the suffering.

"Now there is one like him in the person of the physician from the distant West, where speech and customs have nothing in common with those of China.

"Last autumn I fell ill with a carbuncle, and could not have lived to the winter. Dr. Lan (Randle) gave me healing medicine and cured me: though I was four months ill he made me well.

"This Dr. Lan has certainly the power of life and death in his hands.

"In the 18th year of Kangsu, the Recipient of Kindness, Wu-Shui, Respectfully records this."

The British Medical Journal

says:—

"We have submitted the LACTOPEPTINE
"to trial, and can confidently recommend it."

The Medical Press and Circular

says of LACTOPEPTINE:—

"Such a formula is a desideratum, considering that the preparations of Pepsin now in use have disappointed the expectations of many practitioners."

Braithwaite's Retrospect

says:—

"A glance at the formula of LACTOPEPTINE would convince even the most sceptical of the valuable results that must ensue through its administration. Composed of *ptyalin*, *pepsin*, *pancreatine*, *hydrochloric* and *lactic acids*, it is a combination of all the digestive agents, consequently can never be administered without giving the utmost satisfaction, for if there is a deficiency in the system of all or any of these agents LACTOPEPTINE will supply it, and thus assist in digesting the food, enabling the organs that produce these principles of digestion to rest and recuperate their relaxed energies."

Lactopeptine.

LONDON.

I think your preparation

LACTOPEPTINE

a very useful one, more especially in the continued fever. During the latter part of last year I used it in four cases of typhoid, and in every case there was a marked improvement in the intestinal symptoms immediately following its use. I think this result was due to the Lactopeptine supplying the place of the intestinal and gastric juices, produced in very scanty quantities in this disease. I think this is a remedy of the first importance in typhoid fever.

W. VERNON, F.R.C.S.

410, Brixton Road, S.W.

LONDON.

The value of

LACTOPEPTINE

in many forms of indigestion cannot fail to be recognised by every prescriber, as soon as the formula for its composition is seen. The proportions in which the active principles are combined are those required for the healthy digestion of the various food matters found in a mixed diet. I consider it, therefore, as perfect a "digestive" as can well be obtained.

G. OVEREND DREWRY, M.D., &c.

57, Queen Anne Street, Cavendish Square, London, W.

LIVERPOOL.

When Pepsin has failed to increase the secretions of the gastric juice and relieve the dyspepsia, I have prescribed the

LACTOPEPTINE, with much remedial benefit. I have a profound conviction of mind with regard to its remedial power in dyspepsia, and Pepsin is not to be compared with it. I have found it useful in giving power to the stomach, in marasmus, or chronic muco-enteritis, relieving the sickness, and giving tone to the mucus membrane of the intestines, so as to reduce the purging.

JOHN P. BURROWS,

L.R.C.P. Edin., M.R.C.S., L.S., at

London.

Ivy House, Aighurth Road, near

Liverpool.

LIVERPOOL.

I have found it very beneficial in many cases of dyspepsia, and in relieving the morning sickness of pregnancy invaluable.

EDWARD PARKE, M.R.C.S., &c.

West Derby Dispensary, Liverpool.

I have received the treatise on

LACTOPEPTINE, which I shall give to a junior confrère, as I have given that valuable peptonising agent with immense success for several years to dyspeptic persons.

THOMAS SIMPSON,

M.D., M.R.C.S., &c.
77, Upper Parliament Street, Liverpool.

GLASGOW.

In reply to your letter, received this morning, I beg to remind you that last year, after using your

LACTOPEPTINE,

in several cases, I sent you a letter, which afterwards appeared in *Medical Reprints* expressing my firm belief in its efficacy. Since that time I have used a considerable quantity of it, and have every reason to repeat what I then said in its favour. It is certainly the most successful remedy I have ever applied in cases of indigestion arising from an atonic condition of the stomach.

ROBERT ALDOUS,

L.R.C.P. Edin., L.R.C.S. Edin., and

L.M. and L.F.P.S. Glasg.

Exchange Square, Beccles, Suffolk.

GLASGOW.

I have, on several occasions, found

LACTOPEPTINE

give most satisfactory results when previous use of pepsin has failed to afford any relief.

G. YEAMEN, M.D., &c.

2, Albany Place, Glasgow.

I have used Lactopeptine for several years, and find it very efficacious in my experience.

J. K. ROBERTSON, M.D., &c.

20, Ardgowan Square, Glasgow.

DUBLIN.

I have frequently prescribed your

LACTOPEPTINE,

and invariably with the most satisfactory results. I consider it by far the most valuable digestive medicine before the profession.

WILLIAM LYON,

L.A.H. Dub., L.M.

Donnybrook, co. Dublin.

NORTHAMPTON.

In answer to yours of to-day, I have obtained the same results as those described by other medical men, whose letters are printed in the pamphlet. I consider

LACTOPEPTINE

the best remedy for indigestion, and I have derived great benefits myself personally.

JOHN M. BRYAN,

M.D. Aberd., F.R.C.S. Eng., L.S.A.

36, May Fair, Northampton.

BRADFORD.

I have prescribed

LACTOPEPTINE

for many years, and carefully noted its admirable qualities. In cases of atonic dyspepsia, especially in connection with anæmia, I have found most excellent results to follow the use of this digestion-compelling medicine, if I may make use of such a term as expressive of its action. As it restores the digestive function, and improves the condition of the blood, it is a curative agent and not merely palliative and temporary.

REGINALD G. ALEXANDER, M.A.

Camb., M.D., &c.

Hon. Sen. Phys. to the Bradford Infirmary; Consulting Phys. to the

Lords of the Admiralty.

Manor Chambers, Bradford.

BRISTOL.

When you first sent me a sample of your

LACTOPEPTINE

I was living in Montgomeryshire. I then tried it, and have prescribed it rather extensively ever since.

In my opinion it is a most excellent preparation.

E. T. D. HARRISON,

F.C.S. Eng., L.S.A., J.P.

23, Cornwallis Crescent, Clifton, Bristol.

BELFAST.

I have been accustomed to prescribe your

LACTOPEPTINE

in cases of dyspepsia and persistent diarrhoea in children with the most unqualified success. One of my patients, aged fifty, was completely cured by its use, after ten years taking medicines of all kinds, natural mineral waters, &c., &c., without any result. I, myself, found benefit from it.

I need scarcely say I shall continue to prescribe it to my numerous patients suffering from stomach troubles.

THOMAS BALL,

L.R.C.P. & S. Edin. and L.M.,

L.A.H. Dub., L.M. Coombe Hosp.,

Dublin.

12, College Square East, Belfast.

BIRMINGHAM.

I have used your

LACTOPEPTINE

in my practice for some months back with marked benefit, more especially in constipation and diarrhoea, and I am now prescribing it in cases of "improper feeding amongst infants," particularly those in which unbaked starch foods have been the staple food.

W. WRIGHT WILSON,

M.R.C.S., F.R.C.S., &c.

Belgrave House, Birmingham.

(Now removed to 21, The Crescent, Birmingham.)

HULL.

The excellence and uniformity of the composition of your preparation

LACTOPEPTINE

renders it unapproachable in the treatment of dyspepsia and kindred ailments.

WILLIAM HOLDER,

M.R.C.S., &c.

10, Somerstown, Holderness Road, Hull.

HASTINGS.

In answer to your letter respecting

LACTOPEPTINE,

I beg to state that ever since I first heard of it I have invariably prescribed it in my practice, and found it most beneficial, especially in that chronic and troublesome form of indigestion known as "water brash," and, in fact, in all forms of indigestion it is invaluable.

HARRY G. SHORTER,

M.R.C.S. Eng., L.S.A.

Paragon House, Hastings.

WEXFORD.

An old dyspeptic patient of mine called just as your

LACTOPEPTINE

reached me, and I gave him four 10-grain doses. This morning he called again and begged me to give him some more, as he never received such relief from any other medicine.

H. H. BOXWELL, M.D., &c.

Infirmary House, Wexford.

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The second patient was suffering from syphilis of throat, mouth, and tongue, and had been under treatment at several Metropolitan hospitals, presumably with the usual anti-syphilitic remedies. This was a case of the later class of syphilitic manifestations, viz., those of a gummatous character. The lesions were severe and deep, and there were signs of the same disorder affecting the cerebrum. I must confess to be one of those who regard mercury alone as being of any real use in syphilis, and therefore I must say that I was somewhat surprised at the rapid improvement this patient made under 1 drachm-doses of the remedy. The fissure in the tongue began to close, and a nasty deep ulcer of the lower lip is almost well.

There is evidently some potent influence in the preparation, but in which of the remedies, or whether in the combination, I cannot say. The facts are as I have stated. Our arsenal of weapons against this horrid disorder is not over well filled, and you certainly have provided a remedy which does neutralise the poison of syphilis in some cases. It is only fair to tell you what I have found the medicine to do, and without indulging in a eulogy of it, I must say that under similar circumstances I should certainly try it again.

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F. W. RING, M.D., Assistant Surgeon to Manhattan Eye and Ear Hospital, New York.

MEDICAL REPRINTS

Home, Foreign, and Colonial: with Original Essays.

VOL. IV.]

LONDON: JUNE 15TH, 1893.

[No. 41.

ON URETHRAL FEVER.

By P. MACLEOD YEARSLEY, M.R.C.S.Eng., Surgeon to the Farringdon General Dispensary.

[An Original Article specially written for MEDICAL REPRINTS.]

THE constitutional disturbance which has been variously termed "urethral," "catheter," or "urinary fever," is one of great importance, and one which is but too vaguely and inadequately treated in the text-books on surgery. It is very necessary that every surgeon should have a clear idea of this complication of operations on the genito-urinary tract in all its varieties, for its consequences may be so serious that it should never be lost sight of, and careful prophylaxis employed in every case in order that it may be avoided or at least rendered less severe.

Putting aside the occurrence of orchitis and epididymitis, the effects to which mechanical irritation of the urethra may give rise are best divided into five varieties, as follow:—

1. Shock.
2. Acute transient febrile attacks.
3. Recurrent acute transient febrile attacks.
4. Acute septic infection with metastatic abscesses.
5. An insidious condition unaccompanied by well-defined symptoms.

Pathology.—There has been considerable difference of opinion as to the way in which these manifestations arise, and their origin is still a matter of dispute. Two theories have been put forward, both of which are probably right. They are the neurotic and septic. The exponents of the former theory consider urethral fever to have a neurotic origin. It is much more likely to follow operations on the membranoprosthetic urethra than those on other parts of the tube, and it is this region which is most sensitive and most richly supplied with nerves. The sympathetic nerves which supply the urethra come from the abdominal plexuses, and are consequently continuous with, among others, those which supply the kidneys. It is, therefore, easy to understand how interference with the urethral sympathetic nerve supply may cause reflex congestion of the kidneys. With regard to the septic theory, there is no doubt that septicæmia may occur through the urethra, but the assertion that all cases of urethral fever are septic cannot be considered as settled. In nearly all cases there is some evidence of a wound, and in most instances there is generally a quantity of septic material present, such as stale urine, or putrescible matter may be introduced by means of dirty instruments. It is a significant fact, too, that the rigor which ushers in the attack often first comes on when the patient first micturates after an operation. In the variety which is characterised by acute recurrent attacks septicity is most probably the cause, since they appear without any fresh irritant being applied to the urethra.

The question of pathology is, however, still *sub judice*, but we may say that the balance of evidence is inclined in favour of the septic theory, although that of the neurologists cannot be disregarded, the nervous mechanism having undoubtedly some participation in the condition.

Additional light has been thrown on the matter by different treatments. The adherents of the neurotic theory have advised the use of morphia and similar nerve sedatives, which has not met with that success which the theory of their application would warrant, while perfect antiseptics have been found very potent, especially as a prophylactic.

It is the variety which we have mentioned last on the list as characterised by insidious and ill-defined symptoms which seems to depend more nearly on nerve disturbance. In this condition, owing to the irritation of the urethral sympathetic, the renal nerves (belonging to the same system) are reflexly excited, and congestion follows, which interferes with the

secretory powers of the kidneys (probably already diseased, as will be seen further on) to such an extent as to render them unable, as it were, to single out the substances which they should eliminate. In consequence, a condition analogous to uremia supervenes, which eventually proves fatal.

The treatment of catheter fever is of great importance, and is best considered, with the manifestations of each variety in detail.

1. *Catheter Shock.*—On the passage of a catheter the patient may merely faint, a condition for which we need scarcely mention treatment. He may, however, fall into a condition of shock and collapse, which may kill him within twenty-four hours, and young men who appear otherwise in robust health may be thus carried off, an event not unlikely to occur in Holt's operation for splitting a stricture, a procedure which is now fast becoming obsolete. In this fatal variety, if the kidneys be examined *post mortem*, they will be found intensely congested. Treatment does not differ from that of ordinary severe shock. The surgeon must endeavour to relieve the renal congestion by hot stupes or dry cupping to the loins. The question of stimulants is a difficult one. If it is possible, they should be avoided.

2. *Acute Transient Attacks.*—The fever, as has been mentioned, comes on generally after the first attempt at micturition. A rigor generally ushers in a high temperature, which may reach 105° Fahr., whose fall is accompanied by profuse sweating. The patient experiences pain in the back, loins, and limbs, with nausea and occasional vomiting. The urine is diminished in quantity, or may be suppressed, and hæmaturia may follow. It is said that malaria predisposes to this variety. The average duration of the attack is about twenty-four hours, but it may be prolonged for another twelve or more.

It may be the precursor of an attack of acute nephritis, a condition to which a sustained temperature generally points. The patient may eventually die from acute nephritis with multiple renal abscesses. The treatment of this variety must be prompt. During the rigor the patient must be wrapped up in blankets, hot bottles applied, and stimulants, such as hot tea, &c., administered. Alcohol should be strictly avoided. Croton oil, or elaterium, should be given during the sweating stage, and the patient kept quiet, and his clothing lightened. Should suppression of urine ensue, vapour baths, hot stupes, or dry cupping to the loins may be employed. Pilocarpine sometimes proves useful. The application of hot stupes to the lumbar region is to be recommended in all cases.

3. *Recurrent Acute Transient Attacks* do not differ in signs and treatment from the single attack just discussed. It may be added that it is advisable not to again attempt catheterisation in such cases.

4. *Acute Septic Infection with Pyæmic Lesions* do not differ from similar processes occurring elsewhere.

5. *Insidious Attacks.*—The condition characterised by insidious and ill-defined symptoms progressing slowly but surely to a fatal result occur especially in old men the subjects of enlarged prostate, particularly when there is much residual urine in a more or less septic condition. After catheterism the patient gradually loses health and strength, and dies in from six weeks to as many months. There seems to be a gradual decay of all the vital powers. As has been pointed out, these cases have generally already diseased kidneys. Once the condition is started no treatment is of any avail, but by careful prophylaxis the disease may be avoided. The urine should always be examined before operating, not once, but frequently, so that an accurate knowledge of the state of the urinary organs may be obtained. The patient should be kept for some time in good hygienic conditions, in an equable temperature, and the skin and bowels should be brought into as healthy and active a state as possible.

1, Welbeck Street, London, W.

THREE CASES OF SYPHILIS; TWO OF NON-GENITAL INFECTION.

By J. A. DIGGLE, L.S.A., Lond.

[An Original Article specially written for MEDICAL REPRINTS.]

DR. GOWERS sums up his recently published book on Syphilis and the Nervous System, after discussing the means of preventing infection, and lamenting the repeal of the C. D. Acts, in these words, "One means alone remains, old as the malady itself, by which it can be prevented; one method alone is possible, is sure, and that one is open to all. It is the certain prevention secured by absolute and unbroken chastity." Certainly this method would have prevented nine out of every ten cases which come under our notice, but that it would not prevent all will be shown by the two first cases which I report below.

I also notice that Dr. O. V. Petersen has communicated to the St. Petersburg Syphilidological and Dermatological Society five cases of non-sexual infection, and another Russian doctor has also reported five cases; and in addition isolated cases are also mentioned.¹ If I remember rightly, some physician collected statistics of about forty cases, which were reported a short time ago in one of the German periodicals. Under these circumstances, I thought the two cases now brought to notice might be interesting.

I satisfied myself by every means available that there was no imposture in either, and that the cases had really originated in the manner specified, and I think both may be set down as purely non-genital infections.

CASE I.—Lizzie L.—, a very pretty looking girl of about nineteen years of age, was brought to me by her mother suffering from sore throat and a sore on her lower lip, a little to the right of the median line, which I recognised at once as a typical hard chancre. The parents were very respectable people, the father foreman in a large dye-works. The girl was said to be very steady and quiet, following no employment save helping her mother in the house-work, and was not in the habit of going out alone at night or frequenting any loose places. She was also engaged to be married. I examined the sore very carefully, and confirmed thus my first hasty diagnosis, but said nothing to the girl. Getting the mother on one side, however, I told her (to her extreme grief and horror) what I thought. I elicited from her that her daughter had been to a party at Christmas, and in the course of some game had been kissed by a man present who happened to have a broken front tooth, and this had caused a slight wound, which at first seemed to heal all right, but which had afterwards broken out in the sore then showing on the lip. I examined the girl carefully, but found nothing wrong with the genitals, and then afterwards sent for her intended husband, thinking it might be from him the infection proceeded. When he came, and I mentioned the reason, he at once proffered an examination, and denied strongly any syphilitic complaint; nor, on examination, could I find the slightest trace of either recent or remote syphilis. This turned my attention to the man who had given the kiss, and I got the mother, who knew him well, to ask him to call on me. When I explained matters to him he was much grieved, and confessed to having been under treatment at the time for secondaries. He behaved very well under the circumstances, and, being fairly well-to-do, paid all expenses, and, I believe, gave the girl a handsome present as well. The sore soon healed under treatment, and six months after the girl showed no signs of any disease at all. She got married in about twelve months after; but whether she has shown any signs of syphilis since I cannot say, as the whole family moved away shortly after.

CASE II.—H. G., a man of about forty years of age, came to see me one day suffering from a sore on the chin, just above the site of the left mental foramen. He had been cut when being shaved a short time before, and this sore had developed after the cut. It was a typical hard chancre, and my first thought was that the man had perhaps inoculated himself from a genital sore. But this was not the case; the genitals were perfectly sound. Sore throat and an eruption breaking out removed any doubt (if there was any) as to its being specific. In trying in this case to trace the infection to its source, I was rather puzzled. Did the barber inoculate the man with his fingers, or had the razor some infection on it from a previous customer? I mention the barber, because there was no doubt of his being infected; in fact, the disease had broken out on him several times, never having been thoroughly eradicated from his system. I am inclined to

think that in some way the fingers carried the poison into the wound in the process of shaving.

How this case ended I do not know. The man was a weakly cachectic factory worker, and as he did not improve as quickly as he thought he ought he left me and went to some quack in Oldham, but a relative of his told me shortly after that he had gone back instead of improving, and that his face was an "awful sight." Probably the ulcer had become phagedenic.

CASE III.—This case I should not occupy your time by noticing but for the marked manner in which she recovered under the exhibition of succus alterans (McDade). M. J., a married woman, had caught syphilis from her husband directly after marriage, and had had all the usual symptoms, and seemingly recovered some years before she came under my care.

Her first child shows decidedly syphilitic traits, and her two next were both born dead and putrid.

She came to me soon after her fourth confinement, suffering from well-marked symptoms—sore throat, a rash, and also a peculiar scaliness of the palms of the hands and fingers, the thickened epidermis peeling off and cracks appearing in the folds of the skin. She had been ill after her first child was born, but not so bad as this time; but after her two dead children she had been free from any external manifestations of the syphilitic taint.

I put her on iodide of potassium and hg. perchlor. with gentian, with the result that all the symptoms, except the affection of the hands, soon disappeared.

This, however, was extremely obstinate, and although I increased the drugs until the gums got quite tender, and tried all sorts of tar soaps, yet it did not go away.

I then tried mercurial inunction and mercurial vapour baths, but without avail; and, as I found out afterwards, she had been taking pot. iod. and decoct. sarzæ. on her husband's advice at the same time as the latter treatment, I felt sure that mercury and iodine would not cure her. She had now been under treatment over two months, and was getting thoroughly sick of drugs, so as a last resort, called to mind by seeing the advertisement in MEDICAL REPRINTS, I ordered a bottle of succus alterans from the druggist, and began a trial with that medicine.

In order to try it honestly I stopped every other form of treatment, save an outward application of glycerine and carbolic acid to the hands to keep them moist.

At the end of a week she was not much better, but I persuaded her to persevere, and doubled the dose of the McDade (3j.), thinking it perhaps too small. At the end of the next week she was decidedly better, the third week better still, and now more hopeful of getting well again, which before she had doubted.

Suffice it to say the month end saw the hands gradually covering over with new soft skin and in six weeks they were as well as ever; with skin as soft and supple as at any time in her life. Since then (June, 1892) she has had no relapse. I put down the whole good result to the succus alterans, as the glycerine and carbolic acid had been used before with no effect.

OSTEITIS DEFORMANS (PAGET), WITH REPORT OF TWO CASES.

By HENRY LING TAYLOR, M.D., New York.

[Read before the American Orthopædic Association, New York.]

OSTEITIS deformans (Paget) is a chronic inflammatory disease of advanced life affecting the long bones, spine, cranium, and pelvis, and characterised by pain, hypertrophy, and softening, so that the bones which sustain weight, as the leg-bones and spine, become curved. The bones of the face, hands, and feet are rarely affected, the joints are not involved, and suppuration does not occur.

As pictured by Sir James Paget in his original paper "On a Form of Chronic Inflammation of the Bones," published in the *Lancet*, November 18, 1876, and in the "Medico-Chirurgical Transactions" of 1877, the disease stands forth, sharply differentiated from other affections of the bones, and claiming clinical and pathological recognition as a distinct morbid process. Similar cases have been described by others, and the name had been used by Czerny² to describe an entirely different affection; but Sir James Paget's graphic, masterly, and original study was the first to awaken interest, and to him more than to any other we owe our knowledge of the subject. Other able observers in England, notably Lunn, Mackenzie, and Hutchinson, have since studied this

¹ Vide Prov. Med. Journal. Periscope, May, 1893.² Wiener. Med. Wochenschrift, p. 896, 1873.

affection, described specimens, and reported cases; a few cases have been reported in France, scarcely any in Germany or Italy. An important series of papers in the *Illustrated Medical News*, 1889, and in the *Medical Press and Circular* for 1890, have confirmed Paget's observations of the clinical history, symptomatology, and pathology of the affection. Thibierge was able to collect forty-two published cases to add to his own, which he published with an admirable *résumé* of the subject in the *Archiv. gen. de Med.*, January, 1890.

In America, McPhedran and McKenzie in Toronto, and Gibney in New York, have reported cases of this affection; others, reported by Lippincott, Daly, Ellinwood, and Wightman, cannot be accepted as instances of Paget's disease.

Of the forty-three cases analysed by Thibierge, twenty-one were men and twenty-two women. The onset was, with very few exceptions, after the age of forty; the average age of thirty-two cases was fifty-one years. One case has been reported which began at thirty (Case XXI.), and one at twenty-eight (Case XIX.); a few began as late as sixty-five.

The disease does not seem to be hereditary, or except in rare instances to run in families. In one instance two brothers (Cases XXVIII. and XXXI.) were affected; in another, a female (Case XXII.), the father and brother (Case XXXIV.) had possibly suffered.

Mr. Thomas Bryant followed one of Paget's original cases till death at the age of seventy. The patient had no brothers and but two sisters; these were beginning to show signs of the disease at the time of his death.

No connection is traceable between this disease and syphilis, tuberculosis, gout, or rheumatism. It is probably a general disease, with its principal lesions in the osseous system, and depends on some anomaly of nutrition of undetermined origin (Thibierge).



FIG. 1.—Section through the Skull from a Case of Osteitis Deformans.—Mansell Moullin.

Of eight of Paget's cases traced to the end, five died of cancer or sarcoma; and of twenty-three cases observed by him, four became blind.

The onset is insidious and the progress exceedingly slow. The first symptoms are often a dull or severe aching in the affected bones, which may persist throughout, but in some cases pain is absent, and the gradual enlargement of the head, often necessitating a larger hat,¹ or increasing deformity of the spine, tibia, or femur may be the only symptom noticed. The bones most frequently affected are the tibiae, femora, clavicles, spine, and vault of the skull, in the order named. The pelvis is not rarely broadened and thickened. There is a tendency to symmetry in the lesions, but there may be marked deviations. The disease may rarely be confined to a single bone, as the femur or tibia, and early in its course it is often confined to one or two. The pathological process is inflammatory rather than degenerative, and of extreme chronicity. The bone structure shows a mixture of rarefying osteitis, with the Haversian canals large and irregular, sometimes notched at their edges; and of formative osteitis with certain Haversian canals narrowed, and lamellæ of recent formation. As is usual in mixed lesions, the systems of lamellæ which surround the Haversian canals lack the regular arrangement of the normal tissue, and are turned in different directions. The vessels and Haversian canals are not dilated. It is probable that the marrow is more or less affected (Thibierge).

The process results in a gradual enlargement of the diseased bones, so that the skull may attain to three or four times its normal thickness, with obliteration of the diploë, and the long bones add materially to their length and

perhaps double their circumference. The enlargement is fairly even and uniform throughout the affected bone, though the surface may be slightly bossed. Coincidentally with this enlargement the bone becomes softer, and bends to the superincumbent weight. The femora and tibia especially, if affected, become markedly bowed outward and forward, so that the knees are separated by several inches. The trochanters rise above Nélaton's line by reason of the diminished angle between the neck and the shaft of the femur. In well-marked cases the thighs are everted, and the hips and knees somewhat flexed. The joint surfaces are not affected unless by some accidental complication, though motion may be somewhat limited by the nature of the deformity, and possibly by ligamentous rigidity or thickening.

The spinal deformity is quite characteristic. There is commonly a bowing forward of the spine, and this is usually more prominent in the upper half, while the lumbar region loses its concavity and becomes straight. The head is carried far forward and droops towards the chest. The shoulders are round and stooping, the chest sunken toward the pelvis, the costal breathing shallow, and the belly pendulous. The spine is nearly rigid, and may be the seat of severe pain. Instead of this antero-posterior curve, there may be a lateral curvature of the spine, developed late in life. The general appearance, attitude, and gait of the patient are strikingly modified by these changes. The height may be diminished by several inches, the trunk and legs seem short, while the arms retain their natural size, and the hands hang near the patient's knees. The head is large and carried forward by the bent neck and spine, and this with the bent and separated knees and "slow and awkward" gait, gave the patient a dwarfish or simian aspect exceedingly striking and readily recognised.

The bone does not appear to be brittle, and fractures are rare; when they do occur they unite without difficulty. It will be observed that the general appearance is somewhat suggestive of extreme senility, or of paralysis agitans where the deformities of the skull and long bones are, of course, lacking. The attitude and spinal deformity resemble those of the extreme form of arthritis deformans, known as "spondylitis deformans," but the joint lesions in the latter affection easily distinguish it. As the bones of the face, hands, and feet only are affected in acromegaly, it is easily differentiated from osteitis deformans.

If the characteristics and site of the bony enlargements and deformities, the age of the patients, the fact that the joints are exempt, and that there is no tendency to suppuration, are remembered, the differential diagnosis should not present serious difficulties.

The progress of the disease is exceedingly slow, and with little apparent effect on the health of the patients, who often live to an advanced age, and usually succumb to some complicating affection. The therapeutics of this malady is unsatisfactory; nothing has been found to arrest or favourably modify its progress. I have regretted that in the first case to be related I did not try the effect of antero-posterior support to the spine by means of a properly constructed leverage apparatus. It has seemed to me that, in cases where the backache was severe, such treatment offered some prospect of relief, and I intend to try it, should a suitable opportunity present itself.

In England, the only country where it appears to have been well studied, the disease does not seem to be very rare, and it is not unlikely that, as its characteristics become more familiar to the profession, many cases may be reported in other countries.

In August, 1891, a gentleman, aged sixty, whose very peculiar gait and attitude at once attracted my notice, called to consult me in regard to a distressing backache, from which he had suffered some ten years. His back was much bowed, especially in its upper half, and his neck was bent, so that the head, which was very large, was carried forward, and at the same time dropped toward the chest. His figure was dwarfish, and his height did not appear to exceed five feet, as he stood in his habitual attitude, with the legs a little



FIG. 2.—Femur from Case of Osteitis Deformans. — Humphrey.

¹ In Paget's first case the hat measure increased from 22½ inches in 1844, to 27½ inches in 1876, but the head retained its natural shape. It may appear square or somewhat bossed. Even when the skull is enlarged, pain in the head has not been observed.

flexed at the hips and knees. The latter were somewhat separated, and the legs appeared short, but the arms seemed very long in proportion to the length of the body. Though my patient's intelligence was evidently unusually keen, there was something ape-like in his figure, and in his awkward, half-shuffling gait, which produced an impression differing from anything I had even seen.

My patient was a lawyer, born in England, but for many years a resident of Canada; a hard worker, and of regular habits. He had most of his life enjoyed good health, but for ten years had suffered with severe pain across the lower part of the back, shooting out to each side, but not down the legs nor over the abdomen; it was especially apt to come on after rising from the sitting posture, and on the whole had been getting worse. During the same time his body had become bent so that he could no longer stand erect, and five or six years previously he had noticed that the right femur was bowed forward and outward, and this had lately increased; there had been no pain in the legs. He had, he said, lost at least an inch in height in the previous twelve or eighteen months. He instinctively avoided walking, but riding in a carriage did not hurt him.

His family physician, Dr. J. B. Hall, of Toronto, stated that he had been noted for his large head, but could not say whether it had increased in size in the last few years, and I omitted to question my patient on this point.

His digestion had been good and his bowels regular. His water had frequently been examined and a trace of albumen had occasionally been found, but it was usually normal in quality and amount. He did not think he was short of breath.

Examination showed the radials thickened and atheromatous, and a systolic murmur at the base of the heart. The back was much bent in the cervical and dorsal regions, so that the chin could be separated but a short distance from the chest. The lumbar region of the spine had lost its natural concavity, and was straight or slightly convex; the whole spine was much stiffer than normal. The pelvis was large and too little inclined. Both knees and hips were a little bent, the trochanters reached somewhat above Nélaton's line, and extension and rotation at the hips were somewhat restricted, but there was no muscular spasm and no indication of joint trouble. When the feet were placed together, the knees were separated by an interval of three inches, owing to the very marked bowing of the right femur. This bowing extended throughout the length of the shaft in a forward and outward direction, and was more pronounced at its upper end. The femur was larger and longer than normal. The right thigh was also considerably everted. There was no other bone deformity of the legs, but the left femur was probably enlarged.

R. A., $31\frac{1}{2}$; L. A., $32\frac{3}{4}$. In the first measurement the tape just touches the right knee, in the second it is deflected inward. Circumference of thigh seven inches above patella, right, $16\frac{1}{2}$; left, $16\frac{1}{2}$.

Trochanter to external malleolus, right side, $31\frac{1}{2}$; left side, $31\frac{1}{2}$.

Trochanter to knee, right, 17; left, 16.



FIG. 3.—Osteitis Deformans. From Hutchinson.



FIG. 4.—Characteristic Attitude in Osteitis Deformans. From Lunn.

Knee to external malleolus, right, $15\frac{1}{2}$; left, $15\frac{3}{4}$.

The apparent discrepancy is due to the deformity, and possibly to anomalies of the tibiae.

The case was so typical that I at once made the diagnosis of osteitis deformans, in which Dr. Hall concurred.

The resemblance between the femoral deformity in this patient and that in the case of a lady, aged sixty-nine, who had been under my observation since 1888, was so striking that a review of the latter case convinced me that her deformity must be attributed to the same cause. This lady came in 1888 to consult me about her left hip, which had been injured three years previously by a fall on the floor. There were eversion and complete disability at once, but her surgeons found no true crepitus and no shortening. There was excruciating pain behind the hip, down the thigh, and at the inner side and front of knee. She was kept in bed with weight extension ten weeks, and it was nine months before she could with difficulty go about on crutches. Three years after the accident she still depended on crutches, and suffered excruciating pain, for which she sought relief. It is not necessary to go into the further history of the left hip, except to say that she was in time relieved of severe pain, and enabled to walk readily with a cane.

At the examination my attention was attracted by a very marked and peculiar deformity of the right femur, which, on questioning, she said she had first noticed a year after the accident, and which she was positive did not exist before it. The deformity existed in a very marked bowing forward and outward, especially at the upper part (Fig. 5).

The circumference of the thighs at the crotch was 18 inches on the right side, 16 on the left.

R. A. was $31\frac{1}{2}$; L. A., $30\frac{3}{4}$. From the knee to the internal malleolus was, on the right side, $13\frac{3}{4}$; on the left, $13\frac{1}{2}$. From the knee to the external malleolus was on the right side, $14\frac{3}{4}$; on the left $14\frac{3}{4}$.

Trochanter to knee, on the right side, $16\frac{1}{2}$; on the left, $16\frac{1}{2}$.

There was also a moderate rotary lateral curvature of the spine, with the dorsal convexity to the left, which she was equally sure did not exist before the accident. She had had and was having more or less pain in the right (excurvated) thigh; and a few weeks later she said that the pain in the right thigh was worse than that in the left. She never had had pain in the right thigh until she began to walk after the accident; she had had a great deal of pain in the back since the accident. At the time she began to walk she had been obliged to shorten her skirts nearly an inch.

I examined this patient again in the fall of 1891, and found that the spine and right femur were decidedly more bent. Both trochanters were an inch above Nélaton's line, and the shaft of the right femur was very distinctly enlarged throughout. The curving was such that the right popliteal space was fully three inches from the flat couch on which she was lying, and there was a space of $2\frac{1}{2}$ inches between the knees, when the feet were in contact. The left leg was entirely straight. She had fallen twice within a year without known cause, the first time the previous spring, when she had broken both bones of the left forearm near the wrist. These had united with a little deformity, and she then had a good deal of pain in the arm.

Her height was fifty-eight inches without shoes, which was considerably less than formerly. Her pelvis was large for her body, but no enlargement of the head could be made out. She stood pretty erect for one of her age. Measurements showed some diminution in the distance from the iliac spine to the malleolus on either side, but an increase in the distance from the trochanter to the knee, and from the knee to the malleoli.

The typical excessive deformity of the right femur, with pain and thickening, and with a lateral curvature coming on late in life, convinces me that this is also a case of osteitis deformans.



FIG. 5.—Writer's Second Case of Osteitis Deformans.

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VAGINODYNIA—PERINÆAL SPASM.

By E. F. FROST, M.D.

ALTHOUGH vaginodynia is usually included under the title of vaginismus in our text-books, it will nevertheless be apparent that vaginodynia is worthy of separate consideration, and that any clinical facts that can serve to more definitely distinguish the two conditions will be of prime import as regards intelligent treatment.

The history of this affection, from the time of its earliest description to the present, has been that of assertion and denial as to its separate existence; and yet, while it has been clearly recognised by few, by many vaginodynia is not as yet recognised as a separate affection. One of the earliest observers, and the one to whom the term vaginodynia is due, Sir James Y. Simpson, distinguished vaginodynia from vaginismus in that in the former there obtained muscular contraction along the whole vaginal canal, whereas in vaginismus the contraction is merely at the introitus.

The clinical history of vaginodynia is that of the sudden attack of neuralgic pain throughout the female reproductive organs, without apparent adequate cause; attacks so severe, with sharp lancinating pains so intense as to cause such agony that the physician is summoned in great haste. This condition obtains among married and single girls and women. After a duration of this condition for several hours, if left to itself, the pains gradually fade away, the patient falling asleep from exhaustion.

Symptoms.—On approaching the bedside the physician finds his patient in such costume as she may have worn at the time of the attack, because her distress is sufficiently great to prevent disrobing, for her whole being is absorbed in the one idea of pain. Breathing heavily and rapidly, even panting, tossing, and turning, now drawing up the knees, now straightening them, sobbing and groaning, to the question as to where is her distress, she, with a few words as possible, says, "Away down," or "My womb." Possibly already attendants have placed hot cloths to her abdomen, or may have given hot drinks, but to no avail. If the woman be advanced in pregnancy, the question of labour at once arises, but the pain is not remitting, nor has there been any "show," nor have the "waters broken." To be assured, with some but not great difficulty a finger may be introduced into the vagina, when it is determined that it is not a case of labour. If the woman be not pregnant, with no history of uterine trouble, with no history of traumatism, it is very easy to conclude it to be a case of colic of some kind.

But little is usually done in the way of physical examination at the time, because the case demands relief, so that the opiate or anæsthetic is at once brought to bear, the physical examination being postponed until ease is obtained. This obtained, physical examination reveals nothing, absolutely nothing, that could in any way account for the trouble. So, therefore, in accordance with the mystical provision of the specialist, it is decided to be uterine colic, ovaralgia, vaginitis, pelvic peritonitis (masked), coccygodynia, &c. The bladder is not over-distended, nor is there any unusual hyperæmia of the external genitals, nor any tumefaction nor cystic growth discoverable. There is no increase of temperature, although

the countenance be flushed. There is no vomiting, no nausea, except occasionally, and that slight and from the pain. In fact, there is no symptom but pain, and that is gone when the treatment has taken effect. The next day the patient is well in every particular, only, perhaps, and in probability, to soon experience another attack. These attacks may occur again and again with increasing or decreasing frequency, but of no regular periodicity. Should the patient be menstruating at the time of an attack, of course the diagnosis of dysmenorrhœa at once satisfies many, especially when others of the same family have suffered at such times.

Should we on the contrary, make our physical examination at once on meeting the patient, no paliative having been previously administered, we would learn much, and the secret of the trouble would be revealed. The recti abdominalis and other abdominal muscles are tense, and pressure, if sufficient, increases the pain. Hence, according to the law that pressure increases the pain of inflammation and relieves the pain of spasm, we might conclude that we had to do with an inflammation.

Let us now attempt to introduce our finger into the vagina, the patient reclining on the left side, knees drawn up, operator at her back, using the forefinger of the right hand. There will be experienced on the part of the patient the greatest pain at the least touch as the finger is about to pass the introitus, there being felt a tightly contracted sphincter vaginae, to evade which the finger is pressed against the anterior vaginal wall. At once we have the sure conclusion that we have to deal with a case of vaginismus, and the examination is ended for the time being, when, after relief has been obtained from drugs, the etiological factors are to be sought in hypertrophied caruncular myrtiformæ, perhaps.

Instead of trying, however, to avoid the sphincter vaginae when introducing the finger, let the examiner rather avoid the anterior vaginal wall and press backward with considerable force against the sphincter, gradually, even abruptly, introducing the finger farther in, and pressing backward more and more powerfully. Then, as soon as possible to do so without unduly pressing the anterior wall, introduce the middle finger as far in as possible, avoiding the cervix uteri as well as the anterior vaginal wall, by drawing the whole pelvic floor backward. The pressure on the pelvic floor adds nothing to the pain, and, greatly to the surprise of all concerned, the moment the pelvic floor is retracted, using the two fingers as a hook, the pain and distress completely cease, as if by magic. If now the operator relax his pressure the pelvic floor again contracts, and again the patient cries out with pain. If now, while still retracting the pelvic floor, the operator desires to extend his observations, he may lift one of the already introduced fingers against the cervix uteri, when it, the cervix, will be found to be hard, almost rigidly so, and extremely sensitive on its dorsal aspect, but not nearly so sensitive on its anterior aspect. With care and a little persistence, it will be found that the uterus may be moved about quite freely, rigid though it may be in its own contraction.

By this time the operator's fingers and hands, and even the arm, have become tired, but to relax means a renewal of the pain. But he may relax in some degree, for temporary relief to himself. By this time the physician will have concluded that he has to do with a tonic spasm of the perineum, or rather of the whole pelvic floor. Therefore the physical examination reveals this condition of things, namely, a tonic muscular spasm of the muscles of the uterus, abdominal walls, and pelvic floor, whereby the cervix uteri is pressed downward so as to come between the upper and nether mill-stones, the one the vaginal roof of the anterior wall, the other the contracted pelvic floor. The cervical ganglion of the sympathetic nervous supply of the uterus comes in for its share of the squeezing, therefore.

Etiology.—To determine the cause or causes of this affection, is to investigate the general and special causes of muscular spasm. Symptomatic and anatomical considerations show it to be, at least, a reflex neurosis. If reflex, reflex from what? Reflex from nervous irritation, and this is true in whatever part of the body it may arise, whether, uterus, bladder, rectum, vagina, stomach, or brain. Investigation and observation show it to be specially predominant in the hysterical—in fact, in the writer's experience, with but one exception, it has been so, and in that one case there might be question as to an absence of hysteria. This case was dysmenorrhœic. So far, while no doubt any acute or chronic inflammatory condition of the pelvic organs might give rise to the spasms and accompanying hysteria, yet in all but one of the writer's cases, and he believes even in that, the irritation was purely emo-

tional, for careful examination and inquiry revealed no physical cause.

Traumatic vaginodynia the writer has seen arise from too severe manipulation in uterine examination, and also from too harsh applications to the cavity of the uterus.

Diagnosis.—The diagnosis presents usually but little, if any, difficulty. Sudden onset of severe lancinating pain, continuous, in the inferior pelvic region referred to the uterus. The presence often of hysteria, especially the peculiarly coloured iris of hysteria; the presence of the contracted perineum.

The ultimate diagnosis as to cause would be to seek and discover any source of nervous irritation, referable to any primary diseased state, which would properly be discussed under an appropriate heading.

We have to differentiate vaginodynia from vaginitis, cystitis, ovaralgia, passage of renal calculi, coccygodynia, dysmenorrhœa, retention of urine, and neuralgia of the rectum.

The history at once disposes of cystitis and retention of urine, and besides, examination of the urine would determine the former, and the passage of the catheter the latter. Of the neuralgic affections, if there be passage of renal calculi, examination and search for the calculi would determine the result, as would also the location and direction of the pain. Ovaralgia is distinguished by the peculiar sickening pain and its location, and the absence of the perineal spasm. Neuralgia of the rectum, by location of pain and absence of pain in the anterior vaginal wall. Coccygodynia, by the location and absence of pain in the anterior vaginal wall, and want of relief from perineal retraction. From dysmenorrhœa, by absence of the spasm and the discovery of the impediment to the menstrual discharge. The most difficult differentiation is to diagnosticate between vaginodynia and vaginismus. The real difference is to be found in the extent and location of the seat of spasm. In the former, vaginodynia, the contraction involves the whole pelvic floor; in the latter, merely the parts surrounding the introitus vaginae.

It is to be carefully borne in mind that any one, or several, of these conditions may co-exist with the vaginodynia.

The prognosis is always favourable, when there is no accompanying organic cause, as to both temporary and permanent relief.

Before discussing the treatment, attention may well be given to the name applied to this affection. Vaginodynia implies pain of the vagina, and nothing else, and has nothing to do with the cause. While pain is the absorbing symptom, yet equally prominent is the muscular spasm. The immediate cause of the pain being a muscular spasm of all the muscles of the pelvic floor, it is suggested at once to denote this condition by the term perineal spasm.

Treatment.—The treatment evidently is to relax at once the perineal spasm. To do this effectually do not await the slow action of drugs, but at once, carefully avoiding the anterior vaginal wall and cervix uteri, introduce two or more fingers into the vagina, and press back the perineum. Then, with the thumb externally pressing against the lower segment of the sacrum as a fulcrum, stretch to its utmost the vaginal canal, even to the extent of giving some pain from the stretching, even bending back the coccyx. This is to be held stretched for ten to twenty minutes, or until the perineal muscles are sufficiently tired out to prevent their contracting again. This is most tiresome for the physician, but will well repay him. The relief to the patient is instantaneous. Other periodic attacks are quite certain to follow, after an interval of from a few hours to a few days, when the same procedure is to be again employed. Such treatment causes, after but a few applications, an entire cessation of the recurrences of the spasm. The fingers are to be preferred to any speculum or dilator, as they are not so harsh to the parts stretched, and there is no danger of pressure against the anterior vaginal wall or cervix uteri.

Among the drugs in the interval fluid extract of conium and fluid extract of belladonna have been found by the writer to be the best. For obvious reasons opium is to be avoided, except to relieve pain when a physician is not within reach. Curare might possibly be used to some advantage. In the dysmenorrhœic, extract of viburnum, ʒi. every half-hour, during an attack, has been quite efficacious, even without perineal retraction. General treatment to be as indicated.

Remark.—It is the belief of the writer that this perineal spasm is often the most prominent and the really distressing symptom in most cases of dysmenorrhœa.

A CASE OF GENERAL DYSCRASIA.

By F. P. EMERSON, M.D.

IN the fall of 1887, Mrs. S. B—, aged forty-one, consulted me with the following history: Father died of pneumonia, mother died of measles. One brother died of phthisis, one paternal and one maternal aunt and one maternal uncle died of phthisis. History of grandparents negative. Patient of lymphatic temperament and sedentary habits. No previous disease, other than those of childhood, until six years previously, when she commenced to exhibit symptoms of gastro-duodenal catarrh of a subacute type. This was relieved by proper medication, but showed a tendency to recur at frequent intervals. There was a history of two acute attacks that were diagnosed as gall-stones.

At this time the patient was fairly well nourished, and able to attend to her household duties. The skin and conjunctiva were slightly jaundiced, the tongue was red and fissured. Some tenderness of the epigastric and right hypochondriac regions. The temperature and pulse very normal. There was a history of some stomach trouble and looseness of the bowels. The urine was almost bloody in appearance. Examination of the liver, stomach, and spleen was negative. During the next three years after she came under my notice there was a repetition of the gastro-duodenal trouble, with one attack of gall-stones. With each renewal there was tenderness at the epigastrium, icterus, high-coloured urine, nausea, and all the classical symptoms of a duodenal catarrh, which would subside under strict regimen and treatment, only to reappear at intervals of two or three months, so that Mrs. B— consulted me regularly about once in ten days or two weeks until September, 1891, when a general anasarca supervened. With the assistance of Dr. Bryant, of Ludlow, paracentesis abdominalis was performed, and twenty pounds of a greenish serum were withdrawn. During the winter of 1891 my notes show that I tapped her at intervals of two weeks, averaging twenty pounds of fluid, besides using diuretics and cathartics, although not in the heroic doses subsequently employed. In the spring of 1892 I informed her husband that the treatment was merely palliative, and she fell into the hands of some men in the South, who advertised to cure dropsy for thirty dollars. I continued to tap her when necessary. The treatment of the Southern charlatans consisted of a round bolus, the size of a cherry, at bedtime, followed by Epsom salts on rising, until the bowels moved ten or twelve times. This treatment was heroically persevered in without change for a year, when the salts caused so much gastric irritation that they could not be retained. Mrs. B— continued to be about the house, and with her husband's assistance looked after the domestic duties. She steadily emaciated, although slowly, and with the discontinuance of the salts I was obliged to tap her every eight or ten days. The patient was now weak. The abdominal walls were thinned from over-distention, and there was a large umbilical hernia, but she complained of little except her dropsy, and was about the house except on the day she was tapped. Her appetite was good, and she rested well. Physical examination gave negative results beyond showing the existence of some functional troubles which were attributed to obstruction of the portal circulation. Her menses had been regular until within a year. She gradually emaciated and died in January, 1893, two years and four months after developing abdominal dropsy. The urine, in regard to specific gravity and albumen, had always been normal. During this time—from September, 1890, until January, 1893—she was tapped sixty-five times, averaging by actual weight twenty pounds of serum each time. During this period she had taken one hundred and fifty-four pounds of Epsom salts.

Autopsy, by Dr. W. L. Havens, of Chester, and myself. This was performed hastily, and with not as much exactness as it should have been, owing to extreme cold and the fact that the woman's house was ten miles from our office. The body was extremely emaciated. The stomach was dilated, spleen much enlarged, liver and gall-bladder normal. The pancreas was enlarged and infiltrated. The right ovary and uterus could not be made out, but the broad ligament could be easily traced, and at the sight of the uterus was a new growth, of cauliflower appearance, the size of an English walnut. The left ovary was cystic, and the whole pelvis was full of adhesions and a suppurating mass. There had never been any subjective symptoms of any trouble about the generative organs, and during the last two years patient complained of little beyond discomfort. During the last month she would be unbalanced mentally, just before tapping, and afterwards seemed all right.

BOOKS.

[Works for notice under this heading should be addressed to the Editor at 46, Holborn Viaduct, not later than the 8th of the month. Publishers will assist the Editor and reviewers by stating the price of every publication forwarded.]

THE republication in volume form of some of the late Sir Morell Mackenzie's frequent contributions to current periodicals will be welcomed by the public as well as by the medical profession. Though he could on occasion, as the first chapters in the book of his *Essays* (London: Sampson Low, Marston, and Co., 1893) abundantly demonstrate, figure as a vigorous advocate in the defence of specialism in medicine, Sir Morell Mackenzie was far from being a specialist only. His review articles touch on most of those topics of general interest to educated people, whereon medical opinion, and more especially the particular experience of the writer, was sure to be valued by the thoughtful part of the public, to whom alone he addressed himself; and his essays on subjects so diverse as "Yachting" and "The Dreadful Revival of Leprosy," have intrinsic interest as well as the great authority of the author to recommend them to the general reader.

For the rest, it would be impossible to give in a paragraph anything that could be called an account of this most interesting work. Sir Morell Mackenzie's numerous *extra*-professional interests relieve his work from the taint of mere specialistic divagation. Temperate, lucid, genial, and withal earnest, these essays, whose appropriate motto, "*luceo non uro*," is inscribed on the title-page, mark the cultured modernity of thought and feeling which characterised their writer to the taste of the lay public as his high professional repute could, in the nature of things, hardly be expected to do. Mr. A. W. Mackenzie, brother of the great specialist, under whose selective editorship the work is produced, has done his work admirably and with a discretion and reserve especially needed, inasmuch as Sir Morell Mackenzie's review articles were devoted in too many instances to topics of but transitory interest. In one place only, perhaps, will the revising hand of the author be missed—on page 291, where the misprint of "congenial" for "congenital" has been overlooked, an error excusable enough in a lay editor, though it makes rather particular nonsense of the sentence where it occurs. This is one of the pleasing ways of the facetious printer, who also never misses the opportunity to spell chorea "cholera," provoking an opulent anger in the author who may chance to overlook the error until the work is printed, as sometimes happens.

OUR ILLUSTRATIONS.

THE medical profession and the medical schools of London lost an able teacher by the death, on May 21, of

Prof. MARCUS BECK, M.B. Lond., and M.S., F.R.C.S. Eng.,

in the fiftieth year of his age. He was a cousin of Sir Joseph Lister, and his pupil at the Glasgow University in 1860; but his further studies were at University College, London, where he won the highest honours, and was appointed on the teaching staff; and in 1885, after constant highly valued services in the hospital wards and in the lecture theatre, succeeded Professor Marshall in the chair of surgery at that college. He was also a member of the Council and of the Court of Examiners of the Royal College of Surgeons, and was author or editor of many important treatises and text-books.

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

JUNE 15th, 1893.

DR. DOMINGOS FREIRE, of Rio Janeiro, has just published a pamphlet containing his fifth series of statistics concerning vaccinations with the attenuated virus of yellow fever, practised in Brazil during the epidemic of 1889-90. The figures include all the inoculations made in the three towns of Rio Janeiro, Campinas, and Miracema.

In Rio, during the year ending June 30, 1890, there were 721 deaths from the disease—630 among the foreign population, and 73 among natives, the nationality of the remaining 18 being unknown. The percentage of deaths, therefore, to the entire population, estimated at 360,000, was 0.2. During this period there were 97 vaccinations practised, and among the persons thus protected there was 1 death, or nearly 1 per cent. In Campinas, with a population of 20,000, reduced by flight during the epidemic to some 8,000—or say an average during the entire period of 15,000—the total number of deaths was 350, or about 2½ per cent. The number of persons vaccinated was 215, among whom 27 were attacked with yellow fever and 4 died, giving a mortality among those vaccinated of somewhat over 1½ per cent. In Miracema there were 12 deaths from yellow fever in a population of 561, giving a percentage of a little over 2½. The number of vaccinations was 51, with 1 death, or a little less than 2 per cent. Taking the three places together, we find a total mortality among the non-vaccinated of 1,086, or 0.3 per cent. of the entire population. Among the 563 vaccinated there were 6 deaths, a percentage of about 2½.

It is, however, not fair to compare these figures, for we have no means of knowing the foreign population, which comprises most of those susceptible to the disease in Rio Janeiro; hence the mortality among those treated, who were mostly foreigners or susceptible persons from other Brazilian provinces, appears much too high proportionally. But leaving the statistics for Rio out of consideration, we do not see that there was much protection afforded by the so-called preventive inoculations. In Campinas the percentage of deaths among the general population was 2½, and that among the vaccinated was 1½; and in Miracema, where the figures were too small to possess any value, the percentages were respectively a trifle over and a trifle under two per cent. The difference is much too small to offer any argument in favour of inoculation as a preventive measure. It certainly would not appear to warrant the confident prophecy of Dr. Freire, that "epidemics of yellow fever will soon disappear from Brazil;" a prophecy which, in view of the fearful ravages of the disease during the past year at Santos, is at least somewhat premature.

NEWS AND NOTES.

THERE is in Milan a young woman whose spiritualistic powers as a medium have excited great general interest. In consequence of this a committee, which included among its members Professor Cesare Lombroso, Professor Schiaparelli, and Professor Charles Richet, of Paris, undertook an extended investigation of the phenomena, following strictly scientific methods. The performances of the medium, though done by an ignorant Italian peasant, have a strangely "mediumistic" character. There were wrappings, table-tipping, levitation, the usual dark-room phenomena of bell-ringing, face-slapping, luminous arms and faces, &c. The eminent scientists investigated all this with the greatest solemnity, and according to the approved rules of scientific evidence. They finally admitted that they were mystified by the performances but not satisfied; they were not convinced of fraud, yet in no case could an experiment be carried out under perfectly satisfactory conditions. They sign a report admitting their perplexity. It is unfortunate that these gentlemen did not make an experienced prestigator a member of their committee, and also that they did not read a little of the history of spiritualism, and its decadence under the frequent exposures which have been made of its tricks.

A MEMORANDUM, stated by the *Kansas Medical Journal* to be placed at the head of his account-forms by a local practitioner of medicine, must, it is devoutly hoped, be mythical. It is, says our contemporary, "unique, original, and pointed, and, we presume, effective," and reads, "A prompt settlement of this bill is requested. If bills are paid monthly a discount of 10 per cent. is given. Bills not paid promptly will be passed to my attorney for collection. If you pay your physician promptly he will attend you promptly, night or day, rain or shine, while your slow neighbour suffers and waits, as he made the doctor wait, and while he is waiting the angels gather him in."

GLISCHRURIA, or mucous degeneration of the urine, has recently been studied by Albertoni. In two cases examined bacteriologically by him, a micro-organism was found, to which the name of bacterium glischrogenum was given. Dr. Renzi has found the same bacterium in a third case of this affection.

THE *Progrès Médical* gives the following list of "Some Comparatively New Drugs and their Scientific Names," here duly Anglicised:—

COMMON NAMES.	SCIENTIFIC NAMES.
Antipyrine	Phenyldimethylpyrazoline.
Analgesine	Phenyldimethylpyrazoline.
Antifebrine	Acetanilide, or phenylacetamide.
Antinervine	Salicylbromanilide.
Antisepsine	Paramonobromophenylacetamide.
Antiseptol	Cinchonine sulphiodate.
Anisol	Methyl phenate.
Aristol	Iodothymol.
Annidaline	Iodothymol.
Betol	Beta-naphthol salicylate.
Naphthalol	Beta-naphthol salicylate.
Bromol	Tribromphenol.
Cresalol	Paracresol salicylate.
Exalgine	Methylphenyl acetamide.
Hypnal	A mixture of chloral and antipyrine.
Iodol	Tetridopyrrol.
Iodopyrine	Iodantipyrine.
Orexine	Phenyldihydroquin azoline hydrochloride.
Phenethol	Ethyl phenate.
Primuline	Sodium thioparatoluidinesulphonate.
Saccharin	Orthosulphamidobenzoic anhydride.
Salol	Phenyl salicylate.
Salophen	Acetylparamidosalol.
Salipyrine	Antipyrine salicylate.
Sulphonal	Diethylsulphondimethylethane.

THE French Société contre l'Abus du Tabac offers two prizes:—1. Two hundred francs and a medal for the best report

of at least four unpublished cases of disease due entirely to the abuse of tobacco, the report to embrace a consideration of the etiology, symptomatology, &c., of the diseases observed. 2. One hundred francs for a cheap and efficient remedy for the relief of the evil effects of excessive smoking in those who are unable to abandon the habit. The conditions of the award will be furnished by the President of the Society, Rue Ste.-Beuve, 20 sc, Paris.

THE "Moulin Rouge," in Paris, has, according to an American contemporary, recently added to its attractions a man who drinks eighty glasses of beer in an evening. A rival establishment rejoices in the possession of another artist whose special forte is the nightly consumption of a supper of eight eggs, six loaves of bread, four pounds of mutton or beef, three raw cabbages, and olives, pickles, and other appetisers *ad libitum*. They are said to draw greater crowds than Jacques or Succi could ever attract, and the managers of other establishments are scouring the city for big eaters and drinkers, offering high salaries for first-class gluttons. Fasters, in the meanwhile, are at a discount. The glutton has this advantage, as a show, that he can be seen to perform his feat, while the quixotic and unhappy self-starver can but exhibit and expatiate upon what he is not eating, a less spectacular operation.

A FORMERLY thriving trade has come almost to a standstill in consequence of insufficient remuneration to those engaged in it. There is, in Paris, a class of men whose time is spent in dragging the Seine for dead bodies. The city pays fifteen francs for each body found and taken to the morgue, but lately the fishers of the dead have had to wait so long for their pay, that they threaten to abandon their trade, and leave the dead undisturbed in their watery bed. Twelve-and-sixpence for a "machabee," as these bodies are called, is, they say, a small enough price, and when the finders have to wait months for their pay, they feel that their time and labour are wasted. In good times, however, the trade is well worth following, for the Seine is as full of dead as of fish. One "machabee man" has pursued his calling for upwards of a quarter of a century, and has made a fairly comfortable living from it. He is not a very steady worker, but when he sets himself to work with his grappling-irons, he frequently gets three or four corpses in a single day.

A FRENCH physician has obtained good results in dressing burns with milk. Compresses are soaked with milk and laid on the burn, to be renewed night and morning. An extensive burn on the leg was healed in this manner. Two days reduced it in size from fourteen to seven centimetres; at the end of three days it measured but two centimetres and a half in diameter. Another burn, which had been treated for eight days with olive oil and oxide of zinc, healed rapidly under a simple milk dressing.

DR. CORLIEU, writing in the *Journal d'Hygiène* on military surgery among the ancient Greeks and Romans, gives some interesting details. According to him, armies were accompanied by men who dressed wounds, reduced fractures and dislocations, and stopped hæmorrhage. In the reign of Augustus, surgeons were appointed to the regular troops. The Persians were among the first to give attention to hygiene. Surgeons are mentioned by name in the accounts of the military expeditions undertaken by the Macedonian kings. At first they received no remuneration, but later they were paid out of the public treasure, or (says the author, naively), out of the money obtained from the vanquished! It must have been rather hard on the medical profession when the vanquishing was the other way. The author also makes mention of a mounted ambulance corps, instituted in the reign of the Emperor Marius. Their duty was to carry the wounded away from the scene of battle. The first military hospital was established under Trajan.

A CHINESE quack, who recently died in San Francisco, is reported to have had a practice of 45,000 dollars a year, and to have died finally of his own speciality—asthma.

CONTINENTAL PRACTICE.

A CASE OF BIRTH IN THE COFFIN AFTER
MATERNAL DEATH.*Translated by MARIE B. WERNER, M.D.*

A CASE reported (*Kreisphysikus zu Schlochan in Westpreussen*, Bd. 3, 1893) by Bleisch has caused the author, Dr. Moritz, to report one of similar character. The patient, aged thirty-five, fell in labour on Sunday, June 19, at 12 p.m. She was attended by a midwife, who examined her while having severe contractions on the lap of her husband, but decided that she could not deliver the child. She was brought to the edge of the bed, the midwife again using various manipulations with no effect. While she distinctly felt the head, according to her statement, she was still unable to deliver. At 7 a.m. the patient died without having given birth to the child. The funeral took place three days later. Owing to a denunciation made by the gendarmes on the 5th of July, against the midwife as a causative factor in the death of the patient, the corpse was exhumed thirty-eight days after death and thirty-five after burial.

(a.) *External Appearance.*—The female corpse 157 cm. long, well supplied with fat; muscles well developed. The skin is generally moist; whitish-grey colour; face greenish-grey and swollen. The back, breast, and abdomen greenish-grey and moist; and the inner sides of the thighs are soiled and greyish-red. The entire body is covered with blisters varying from the size of a pea to that of a hen's egg, and filled with decomposing gases and moisture. The odour was unpleasant; the upper and lower extremities freely movable. The eye-balls are softened and deeply retracted. The lips bluish-black and moist. The abdomen markedly distended.

Between the thighs lay the corpse of a male child, 24 kg. weight, 49 cm. long, and otherwise having the appearance of a fully-developed foetus. The child lay with its back upwards and the head near the knees of the mother, facing the left side of the mother. The cord was 47 cm. long, the size of a lead pencil in thickness; bluish-black in colour and soft in consistency. The placenta was a bluish-black softened mass, and was almost entirely extruded from the vaginal tract. It was attached in one portion to the uterus, this latter being almost entirely inverted, and presented a large mass the size of a man's head. There was, therefore, total eversion of the uterus together with the vagina. The mucous membrane of both presented a smooth, slimy, reddish-grey surface with green spots, only at the place of attachment for the placenta was the surface rough and greenish-black. The labia majora were almost obliterated, and but traces of the labia minora could be detected between the former and the uterus.

(b.) *Internal Examination.*—The cranial cavity: In opening the cavity the brain was found to have changed to a thin, reddish-grey, offensive mass.

The thoracic and abdominal cavity: The thoracic organs show nothing more than advanced stages of decomposition. The intestines contained in the abdominal cavity are markedly distended. The uterus cannot be found in the abdomen. The region where the uterus had been is marked by an oval opening 3 cm. long, and a half cm. wide. On the margins of this opening are seen radial folds. Pressure upon the inverted uterus causes a discharge into the abdominal cavity of foul-smelling gases, which causes collapse of the organ and permits its reposition. The walls of the uterus are about 6 mm. in thickness, and uninjured. The conclusions arrived at are the following:

(1.) The patient died previous to delivery. (2.) It was not possible to determine definitely the cause of death by section alone, since decomposition had advanced too far. (3.) It is impossible to tell if the patient died of hæmorrhage, or if the death was caused by a third person. The explanation for the birth in the coffin is that by generation of the decomposing gases the child was expelled from the uterus by mechanical pressure.

In closing the author states that in his case there was a certainty that the patient died before giving birth to the child, that at the time of burial, three days later, the child was still in the uterus, and, for that reason, *post-mortem* contractions could not be thought of; while, on the other hand, the presence of decomposing gases in the abdomen of the corpse was sufficient to cause the expulsion of a normally presenting foetus.

AMERICAN OPINION.

THE TREATMENT OF HÆMORRHOIDS.

By JAS. E. PRYOR, M.D., Loganport, Ind.

THERE is no class of diseases more important, falling into the hands of the general practitioner, and for which he should be better prepared to treat than diseases of the rectum.

Within the past few years much practical attention has been devoted to the subject and much has been said and written on this annoying branch of surgical disease.

The frequency with which we are called upon to relieve those suffering from this troublesome affection, behoves us to well acquaint ourselves with the different modes of affording relief. Many of these patients have tried all sorts of "salves" and "pile remedies." The word *operation* is a "bug-b-ar" to them; they are timid and discouraged, anxious for relief, and finally fall into the hands of the general practitioner, and he who can cure them, not only relieves a troublesome disease, but adds laurels to his fame.

Without going into the pathology, or any lengthy discussion as to the different varieties of hæmorrhoids, or the methods of treatment, I merely give an outline of the results of my own thought and experience with a method which I have used successfully during the past three years.

Much has been said and written for and against using injections of carbolic acid in hæmorrhoids, but I believe by using proper judgment and care almost any hæmorrhoid that is a distinct internal growth can be successfully met by injections, and with a minimum of danger. But I would especially caution against using injections of too great strength, or making too many injections at one time. It is better that we do too little than too much. A little extra zealotry or misapplied judgment will cause the patient more inconvenience than his ailment.

When a patient comes for relief from this affection, I do not accept his own statements, but make a thorough examination, both digital and ocular, before making a diagnosis. Having found out the size and extent of the trouble, I prepare for treatment. I direct him to go home, have the bowels moved freely, and order a large enema of soapsuds and water to be taken just before coming to my office.

Having placed my patient in proper position, I ask him to strain so as to bring the tumours down in view, then with a clean hypodermic syringe I inject one drop of minim of pure carbolic acid in the centre of each pile, and then replace it.

If the patient is in good condition, I do not hesitate to inject two or three at one time, but generally it is better for him to present himself at proper intervals until all are injected. After injection I have him put to bed for a week. If there is much pain, it is controlled by an anodyne suppository, or small doses of morphine. After two or three days the bowels are opened freely.

The tumours will atrophy or shrivel up. Only in rare and aggravated cases will a tumour require a second injection; usually the pain is of little account, and in the course of three weeks the patient will go about as usual.

With proper judgment and care there are but few cases that cannot be entirely cured by this treatment. I have never had any dangerous complication whatever occur since I began using it.

OCCLUSION OF STENON'S DUCT BY SALIVARY
CALCULI—OPERATION AND CURE.

By JOHN A. WYETH, M.D., Professor of Surgery in the New York Polyclinic; Surgeon to Mount Sinai Hospital.

M—, female, at the age of two and one-half years, then in perfect health, was struck by a rubber ball on the right cheek. Although the trouble with the parotid duct was referred by the parents to this injury, it is very likely that it had nothing to do with it, since the swelling due to obstruction was not noticed until two and a half years later. The tumour was then incised from inside the mouth by Dr. Kinloch, of Charleston, and the contents—a clean and somewhat viscid liquid—permitted to escape. This operation was repeated on several occasions, but as fast as the wound would close the swelling recurred, and was as painful as ever.

I saw this child in the spring of 1892, when she was six years old. Her face was greatly disfigured by the swelling. Careful palpation under chloroform did not detach any calculi on account of the distention. Suspecting the presence of a lymphangioma (lymphangiectasis), two cases of which I had

operated upon by extirpation, I incised the tumour from the outside. A large cavity, cystic in character, was entered, and as the fluid contents escaped I was able to recognise a series of calculi, five in all, spherical in shape and varying in diameter from one sixteenth to one-eighth of an inch, blocked in the duct of Stenon. This was incised and the stones removed. The external wound was carefully united by silk sutures and an exit for the saliva established through the nervous membrane. The wound healed and the patient made a perfect recovery. It is now almost a year after the operation, and she is still well, with no tumefaction, and a free escape of saliva into the buccal cavity. Some six years ago I exhibited a boy who, as one of the sequelæ of scarlet fever, had occlusion of Stenon's duct by stricture and salivary fistula beneath the ear. The stricture was found by dissection, the duct divided just at the proximal side of the obstruction, and the end carried into the mouth and stitched to the mucous membrane of the buccal wall. In this case the flow of saliva into the mouth was re-established, and the fistula closed by freshening the edges and sutured. These cases are so rare that I desire to put them on record.

AN UNUSUAL SUSCEPTIBILITY TO QUININE.

By L. HARRISON METTLER, M.D., Chicago, U.S.

As everybody knows, quinine sometimes produces marked erythema, with itching. The following case seems to me to be worth recording, for two reasons: First, the smallness of the dose in comparison with the severity of the symptoms, and second, to offset the suspicion of Bartholow, that in most of these cases "the appearances on the skin are merely accidental and not causative." The patient, a young married woman, unusually talented, and inheriting the neurotic type of constitution, was under my care for a severe attack of follicular tonsillitis and pharyngitis. The temperature ran as high as 104.5 degrees, while the pulse numbered 120 to the minute. There were the usual symptoms accompanying high fever, such as headache, dry parched skin, general soreness of the entire body, intolerance of light, extreme restlessness, &c. The tonsils were red and congested, but not so enlarged as one would have expected. The entire pharyngeal vault was engorged and angry looking. There was very little difficulty in swallowing, and no cough. My treatment consisted of belladonna, aconite internally, mustard foot-baths, ice to the throat, the use of an antiseptic spray with the atomiser, and sponging of the entire body. There had been a slow but gradual amelioration, when I was summoned one evening to find a sudden return of the high fever and other symptoms. Staying a while with the patient, I administered ten drops of the tincture of belladonna, with three drops of the tincture of aconite root, and half an hour later gave five grains of antipyrin, repeated in fifteen minutes. At once the pulse rate and temperature began to decline. After remaining with the patient another half hour, I left orders that no medicine was to be administered during the rest of the night. Only the use of the spray was to be continued. The patient told me she was susceptible to quinine, and begged me not to administer it to her. To satisfy myself, however, I left a single-grain capsule to be taken in the morning before breakfast. About eight a.m. I was telephoned to come immediately, and to my surprise found the patient covered with a profuse red rash, wildly walking the floor, and scratching her hands and face so violently that a couple of friends who were with her tried to restrain her from injuring her skin. She seemed quite beside herself, and complained of the intolerable itching. The hands were slightly puffed and the eyes looked heavy. The skin was bright red, an appearance which promptly returned after pressure with the finger. The throat trouble had almost entirely disappeared as well as the fever. The patient declared she would have felt perfectly well if she had not taken the quinine, and with such proof before my eyes she easily secured my positive promise never to administer the drug again to her. As the effects of the quinine began to wear off in about an hour I gave her ten drops of the tincture of nux vomica, ordered her to take a warm bath, and recommended the use of the antiseptic spray only for a day or two longer.

According to Wild, small doses of quinine stimulate the contractile tissues in the blood-vessels as elsewhere, whereas large doses paralyse these same tissues. In my case there was an undoubted idiosyncrasy, which the peculiar nervous type of constitution may have had something to do with. In former fevers from other causes I have noticed in this same patient that quietness and the recumbent position caused the

temperature to be elevated, while bodily activity, as in walking about, produced a singularly marked reduction of the temperature. I am unable to account for the phenomenon, except upon the unsatisfactory ground of extreme mobility or instability of the nervous apparatus. The patient usually enjoys the best of health, and seems to take a keen delight in life and all its attractions. In every way her constitution seems to be physically perfect, but it occurred to me that this unusual susceptibility to the use of quinine was sufficiently interesting to be placed upon record.

PERFORATION OF THE STOMACH, SIMULATING INTESTINAL OBSTRUCTION.

By H. BLANKENHORN, M.D., Orrville, O.

BENEDICT R—, a Swiss, aged about fifty-five, a cooper, and a hard-labouring man, became violently sick on Sunday August 14, 1892. I was called to see him, and elicited the following history: He said that he had been very sick twenty years previous, with abscess of the stomach; he was cared for in a prominent hospital in Bern, Switzerland, and since that time has experienced more or less pain, at intervals, in the region of the stomach. Of late years he has suffered much from constipation, resorting frequently to the use of sulphate of magnesia to effect a motion of the bowels; of late there has been occasional vomiting, with distress after taking food. The patient had been in the habit of taking alcoholic drinks during his life, but I believe not excessively during later years. On the above date he took part of a glass of beer. I was called half an hour later and found him sitting in a chair, in great agony, complaining of pain in the left hypochondriac region. The pulse was rapid and very weak, the face anxious, and the man had the appearance of being in collapse. By the use of hot fomentations and hypodermic injections of morphia he was made somewhat more comfortable. The first twenty-four hours there was no marked change. The patient could not take food and he complained of thirst; the temperature was 101° F., breathing rather fast. I administered olive-oil, and used enemata without a result. On the second and third days there was very little change, temperature 102° F. The man would sleep under morphia. No food was taken and no motion of the bowels took place, although injections were made, with the pelvis elevated, through a large rectal tube. He began now to develop peritonitis, the lower part of the abdomen becoming tympanitic. Diagnosis, perforation of stomach or small intestines near the stomach. Next day a consultation was called, and a good diagnostician with large experience looked upon the case as being one of intestinal obstruction; he advised the continuance of the enemata, but in spite of every effort no motion of the bowels could be effected. The abdomen became greatly tumefied, pulse weaker, general condition more desperate, until on the morning of the sixth day from the above date the patient died. Post-mortem examination showed the abdomen filled with fluid and some pus; the large intestines were empty, the small intestines normal. The transverse colon near the stomach was somewhat inflamed, the stomach normal in size, but presented a perforation one inch in length at the larger curvature, the result of chronic ulceration. A large cicatrix had formed, circular in shape, measuring three inches in diameter, and three-fourths of an inch at the greatest thickness; in the centre of this a cup-shaped erosion or ulceration had been in process, no doubt, for years, until the wall of the stomach was reduced in thickness to that of paper, and finally gave way.

REPORT OF THREE CASES OF SCARLET FEVER WITH SECOND ATTACKS, OCCURRING IN ONE FAMILY.

By J. M. KENNEDY, M.D., New York.

IN Keating's "Cyclopædia" the statement is made that scarlet fever rarely occurs more than once in the same individual, and further on in the same article it says that "the survival of susceptibility is most frequently a family inheritance, and in rare instances changed conditions of life seem to have revived the susceptibility."

In the cases which I have to report both of these conditions seem to exist.

Two years ago I was called to attend Johanna M—, two years of age, who was suffering from a well-marked case of scarlet fever, and at that time there were other cases in the same house. Two older children of the family, I was informed,

had already had the disease in Edinburgh, Scotland. The patient made a good recovery, and the other children, although exposed to the disease, remained in good health.

In January of this year I was called to see Bella M—, eight years of age, who had developed a rash, accompanied with marked angina, and who had been exposed to scarlet fever the preceding week. There was no question about the diagnosis, although the mother informed me that she and her brother were the two who had the disease in Edinburgh, the diagnosis having been made by a gentleman of large experience in that city. Several days after this case developed, James, ten years of age, also came down with the same trouble. This case almost convinced me that the children did not have the fever in Scotland, when the child, which I had treated two years ago for scarlet fever was again stricken down with it. The children all made a good recovery, although the course of the disease was much more severe in the second attacks.

The cases are of interest from the fact that there seems to be a family susceptibility to the disease, and also that the changed conditions of life may possibly have had some influence upon it, two of the children having had the disease first in Scotland and the second attack in this country, the other child having had both attacks in this country.

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

BILIARY COLIC is thought by Frankel to depend at times upon inflammatory adhesions, and that exploratory operation is proper, as cure follows release of the adhesions, even when no calculi are found.

CYSTOTOMY, by incision parallel to that advised by Poncet, passing through the right rectus muscle, where an artificial urethra and meatus are formed has been described by Jabou'ay, in *Le Merc. Med.* Six sutures close the bladder and skin walls, the muscular coat being omitted. The recti muscles seem to exert a sphincter-like action.

HAY FEVER.—Dr. Kyle's plan of treatment is, he says, as follows: First, I cleansed the nasal mucous membrane with an alkaline solution. I then applied to the sensitive areas, by means of cotton pledgets, an eight per cent. cocaine-phenate solution, keeping this in contact with the parts for at least ten minutes, followed by a spray of a solution of the same strength. The result was a diminution of the hyperæsthesia, lessened congestion, the relief of the constant coryza and sneezing that are so annoying in these cases. The treatment failed to benefit the cases in which there was marked hypertrophy. I then removed the thickened membrane, and the result was a partial relief. In cases characterised by reflex asthmatic symptoms an eighty per cent. spray of cocaine was used with most marked effect.—*Medical News*, December 17th, 1892.

MYRRHOLIN is the name under which a solution of equal parts of myrrh in oil to which creosote is added, is known. It is employed by Dr. Kahn in phthisis, and is thought to be better borne than the creosote alone.

CHRONIC ECZEMA of the face is treated by some Parisian physicians by the following application, which is to be made morning and night by means of a brush:—

Salicylic acid	...	...	...	...	3j.
Ichthyol,					
Glycerine	...	...	...	...	āā 3ij.
Peppermint water,					
Lavender water	...	...	...	...	āā 5v.
Alcohol	...	...	...	...	3jss.

Both Salicylic acid and Ichthyol, however, are best applied in a soap, and either can be had in this form from the English agents of Mr. J. D. Stiefel, Offenbach, the celebrated Continental manufacturer, whose British Depôt is at 46, Holborn Viaduct, London.

HEPATIC COLIC is treated by Le Gendre, during the attack, with tablespoonful doses of the following, every fifteen minutes:—

Glycerini	...	...	...	...	3j.
Spt. chloroform	...	...	...	...	3j.
Tinct. bellad.	...	...	...	...	℥xxx.
Tinct. camph. co.	...	...	...	...	℥xx.
Aq.	...	...	...	...	3v.

TUBERCULOUS CYSTITIS is treated by Dr. Talayrach (Thèse de Bordeaux) with injections in the bladder of the following:—

Iodoform	...	...	...	...	25 grams.
Glycerine	...	...	...	...	20 grams.
Gum tragacanth	...	...	...	...	0.15 centigrams.
Distilled or boiled water	...	...	...	...	5 grams.

Using a teaspoonful of the mixture to a litre of tepid water. The bladder should first be emptied and washed with a four per cent. boric solution.

BENZOL or benzene is but little used in medicine, but Dr. Munell gives the following formula, which he has used in influenza and in over a hundred cases of chronic bronchitis and winter cough as an expectorant and sedative:—

R Benzol pur	...	...	...	...	5jss.
Ol. menth. pip,	...	...	...	...	5ss.
Ol. olive	...	...	...	...	3ij.

S. gtt. x—xxx. on sugar every three or four hours.

CHOLECYSTOTOMY is not contra-indicated by the presence of intense cholæmia, as illustrated by one of the cases in Dr. Abbé's report (*New York Medical Journal*). After removal of the gall bladder and duct, a drainage-tube was inserted into the hepatic duct, which would admit a finger. Over this was placed a second tube, reaching from the junction of the ducts, so as to drain all the bile perfectly, the inner tube being removed after a few days, and the outer larger one being left to drain the sinus.

IMMEDIATE CLOSURE OF THE BLADDER in suprapubic cystotomy is possible in a large number of cases after removal of bladder tumours. Albaran reports two cases where complete re-union by first intention took place (*Ann. des Mal des Org. Génit.*, No. 12, 1892), and Tuffier reports in the same journal, an instance where the same successful result was obtained in the absence of any drainage or use of catheter.

MULTIPLE SARCOMATA are found by Sherwell (*American Journal of the Medical Sciences*), to show great modification and amelioration under large doses of arsenic (at times as much as a grain a day of arsenious acid).

CHLOROFORM in typhoid is recommended by Werner after an experience covering one hundred and seventy cases. At first he gives a dessertspoonful of a one per cent. solution every hour or two day and night. In the period of decline only every two or three hours. It appears to diminish the diarrhoea and meteorism.

LOCAL ANÆSTHESIA.—For minor operations the following, used as a spray, is recommended:—

Mentholi	.....	part i.
Chloroformi	.....	parts x.
Ætheris fort	.....	parts xv

SCROFULA as well as tuberculosis is benefited by creosote, which Sommerbrodt administers to children in milk or wine in daily doses not exceeding fifteen minims.

THE TREATMENT OF DIPHTHERIA.—During the past eleven years I have had recourse to several methods of treatment for this disease. By all means the best, to my mind, as borne out by experience, is a fifteen to twenty-five per cent. solution of tr. chlor. ferri et tr. iodini in a menstruum of glycerine and water, or pure water. This should be applied locally to the fauces with a tooth-brush or post-nasal syringe, and should be used as often as every three hours, day and night. Tincture of the chloride of iron, reduced largely with water, is very effectual as a gargle, and as a solvent of the membrane. I also administer ferri chlor. tinct., fifteen to thirty drops in water, every four hours, according to the age of the patient, or a formula like the following:—

R Ferri chlor. tinct.	...	...	...	...	3vj.
Acid. dil. phos.	...	...	...	...	3iv.
Sol. strychniæ	...	...	...	...	3ij.
Sulph. quiniæ	...	...	...	...	3ij.
Aquæ et glycerini	...	...	...	...	āā 3j.–3iv.

M. Sig.: 3j. every five hours, in water.

Beef extracts, spts. frumenti, opii, milk, etc., may be given *ad libitum*, et pro re nata, or in sufficient quantity to maintain the patient's strength and nourishment. If physicians will apply this plan of treatment diligently and in season, very few fatalities, I think, will need to be reported.—JAMES L. GARDNER, M.D.

SUBPREPUTIAL CHANCROIDS are treated by Dr. Cordier by washing with boric acid solution, then injecting one or two grammes of a saturated solution of chloride of zinc, and performing circumcision at once.

"MEDICAL PRESS AND CIRCULAR" ON STIEFEL MEDICINAL SOAPS.

WE have received from Mr. John Morgan Richards, of Holborn Viaduct, samples of various medicated soaps manufactured by Stiefel, at the well-known soap laboratory, at Offenbach (Germany). There is a sublimate soap, containing one half per cent. of the salt which provides an easy and reliable means of securing scabies, phtheiriases. It is also recommended in the treatment of syphilitic eruptions. Among the milder combinations are a borax soap, an ichthyol soap, and a birch tar and sulphur soap. The value of ichthyol in the local treatment of a certain class of skin affections is now generally recognised, and in the form of soap it is peculiarly applicable. The tar and sulphur soap is not only an antiseptic but possesses marked emollient properties, which should prove of service in remedying the disagreeable roughness of the skin which is, in many instances, induced by the use of ordinary soaps. The same remarks apply to the borax soap, which leaves the skin singularly smooth and white. The soap basis is a well-made, perfectly neutral compound, devoid of uncombined alkali on the one hand and of any excess of fat on the other.—*Medical Press and Circular*.

THE LATE DR. WARBURG.

A BOUND book with silver-print photograph, larger than cabinet size, on the late Dr. Warburg's treatment of fever, with letters from a number of distinguished medical men, travellers, and others, and some very interesting facsimiles of Government communications and other documents, may be had, post free, for three stamps, from Dr. Warburg's accredited licensee (who prepares the tincture in strict conformity with the formula, and sells it in bulk to medical men at the rate of 13s. a pound). The supply of this book (which will not be reprinted) is getting small, and early application is therefore advised. Applications should be made to John M. Richards, 46, Holborn Viaduct, London.

A LAYMAN'S LETTER.

A CORRESPONDENT writes:—Although the statements of patients in regard to their condition are useful to the physician in arriving at an opinion, it is not often that their communications are sufficiently lucid, even when, by some circumstance they are led to make them in writing, to convey much information apart from personal examination. The following letter from a person suffering from an advanced form of chronic dyspepsia, or indigestion, is, however, so graphic and accurate in its details, and so emphatic in its obvious conviction, that I have thought it permissible to send it to you for publication. It is not often that so curious a case results in so remarkable a cure, and the treatment is so simple that your readers may be glad to know of the circumstances:—

"DEAR SIR.—I have great pleasure in handing you the following particulars in reference to my cure of Indigestion by the Lactopeptine prescribed for me:—

"For more than twelve months I had suffered from that complaint in its severest form. It commenced with violent pains in the chest and stomach and eructations of wind after eating; and so rapidly did it increase in severity that I had to abandon one article of diet after another, until, finally, I was unable to eat solid food of any kind whatever; a single mouthful of bread was sufficient to give me three or four hours' intense pain. I had, in consequence, to subsist wholly on fluids. I continued in this condition about four months. At the expiration of that period reaction took place; my digestive power seemed to be returning, and for some few weeks I was enabled to observe a partial use of solid foods. But with this reaction came the most fearful symptoms of nervous and physical debility; my energy seemed to have deserted me wholly. Among the symptoms of this stage I may enumerate the following:—Palpitation of the heart, vertigo, intense and almost perpetual headache, drowsiness, bad taste in mouth, coated tongue, inertia, languor, sinking sensation in the stomach—a terribly distressing symptom, with which I had been sometimes rendered prostrate for hours—sallow complexion, feeling of heaviness in the arms and legs, extreme exhaustion following the slightest effort, tremblings, great fearfulness and dread of impending calamity, and, finally, absolute despair. In a word, my condition was truly pitiable. My digestion had again become very weak, and I was compelled to observe a total abstinence from all animal food, and to adopt a semi-fluid diet. But, with scarce a single exception, everything I ate caused me pain and distress. I should not omit to say that two able and zealous physicians had

exhausted their skill on me, and I had made my stomach a complete drug repository, and yet not the least atom of benefit was obtained; my complaint effectually eluded their grasp.

"When my attention was first directed to Lactopeptine it seemed to disagree with me by causing great pain after administration; indeed, I was on this account induced to discontinue its use. But I found subsequently that this pain was the result of its action upon the deranged liver, and having persevered with it a few days, the pain almost entirely ceased. Well, I have now taken three bottles of it, and the result is my headache has entirely left me; also the drowsiness, bad taste, coated tongue, internal sinking, together with all the other evil symptoms which I have detailed above. I have gained considerably both in strength and weight, and with regard to my digestion, I am now able to eat precisely the same as those who are not at all troubled with the complaint.

"I need not particularise further; suffice it to say that I have now every confidence that at no very distant period I shall be as well as I ever was in my life. I may state that I am twenty-three years of age. The mystery to me is, that a preparation of such infinite value is not more widely known and employed. I have recommended it to several friends, and in each case its result has been all that I anticipated.

"I will conclude by saying that for severity I believe my case has scarcely a parallel on record.

"Yours faithfully, _____."

We print the above letter exactly as received from our correspondent.

Lactopeptine is, of course, already largely, and indeed solely, used on the recommendation of medical men. It is a compound of the active principles in the gastric juices by which we digest food in health, and its immediate effect is to restore the healthy function of digestion, no matter how severe or how chronic may be the disorder. It is a drug well known to all chemists and sold by them to the public in ounce bottles at 4s. 6d. The bottle is enclosed in a pink wrapper, secured at the ends, which ensures the genuineness of the powder, and the remedy is a cheap one, since a 4s. 6d. bottle contains enough for forty-eight doses, or sixteen days' treatment.

BACK NUMBERS OF MEDICAL REPRINTS.

The following issues are out of print:—

- | | |
|--------------------------|--------------------------|
| No. 1 (February, 1890). | No. 14 (March, 1891). |
| No. 7 (July, 1890). | No. 17 (June, 1891). |
| No. 10 (November, 1890). | No. 19 (August, 1891). |
| No. 13 (February, 1891). | No. 22 (November, 1891). |

Any other back number will be sent post free to any medical man on receipt of three penny stamps.

[For contents of numbers dated earlier than January, 1893, see former issues of MEDICAL REPRINTS.]

No. 37 (February, 1893) contains:—

Were Protoplasmic Reversions checked by Alcohol? By Wm. H. Pearse, M.D. Edin., &c.; Early diagnoses of Mastoid Disease. By D. Milton Greene, M.D. (With an Illustration.)—Diseases of the Frontal Sinos. By D. N. Rankin, A.M., M.D., &c.; Case of Ununited Fracture of the Femur. By W. Tracy, M.D.; Medical Literature.—I. A Book of the Month. Reviewed by J. E. Bullock, M.D. Brux., M.R.C.S. Eng., &c.; News and Notes.—American Opinion.—Therapeutic Notes.—Portrait: Dr. William M. Polk.

No. 38 (March, 1893) contains:—

Constipation. By J. D. Staple, M.R.C.S. Eng. (Original Article.)—How Amputation of the Breast for Carcinoma should be Performed. By Prof. R. F. Weir, M.D. (With Two Illustrations.)—Spontaneous Cure of Multiple Papillomata of the Larynx after Tracheotomy; with the rare Anomaly of Papilloma of the Epiglottis. (With Four Illustrations.)—Medical Literature.—II. A Book of the Month. Reviewed by F. A. Piggett, L.R.C.P. and S. Edin., &c.—Pooks.—News and Notes.—American Opinion.—Digitalis in Pneumonia; Barium Chloride in Epilepsy: How to Cure Eczema.—A New Disinfectant Soap.—Therapeutic Notes.—Views: The Bristol Medical School: Exterior, Entrance Hall, and Lecture Theatre.

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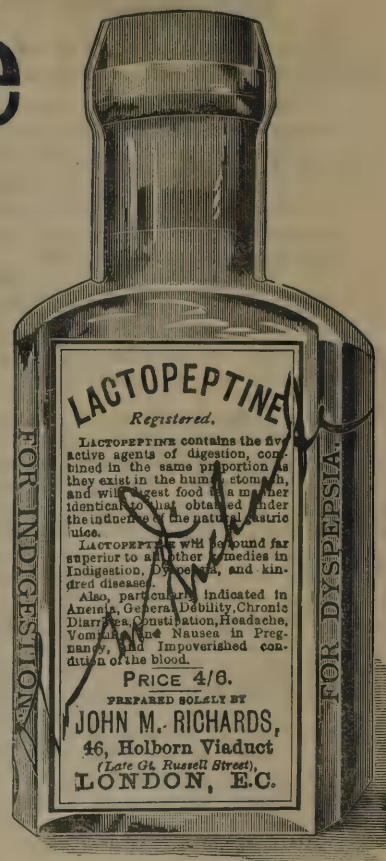
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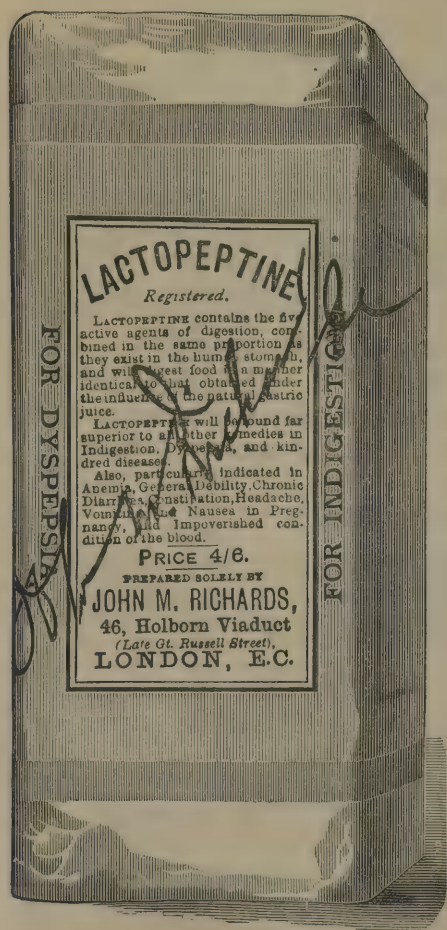
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[No. 42.]

THE PROPER DURATION OF THE LYING-IN PERIOD.

By H. SEYMOUR HOUGHTON, M.D.

IN considering the subject of the puerperal state, or the lying-in period, it is necessary to bear in mind the fact that, although labour and childbirth are truly physiological processes, and hence to be classed among the normal functions of the human body, nevertheless the effects upon the organism produced by these normal functions are of such a character that they must be regarded, from a clinical standpoint, as pathological.

It is for this reason that the position of the lying-in patient is unique—a position of health so near to disease that the patient must be regarded as a sick woman in order to prevent her becoming one.

She is a sufferer from traumatism—has been wounded, and therefore her condition is one which properly belongs to the domain of surgery. For example, a man may undergo amputation of the arm or thigh as a result of injury, and in a day or two, with a normal temperature, good appetite, and undisturbed function, lay as good a claim to perfect health as his neighbour in the adjoining house, who, perhaps, at the same time that his operation took place, was undergoing the pains of maternity. I make this comparison because therein lies the answer to the question, "How shall we classify childbirth and the puerperal state?"

The science of midwifery is but one of the divisions, though, indeed, a large and important one, of the general science of surgery. The obstetrician, even though he may not be able to ligate an aneurism or perform a laparotomy, must be thoroughly versed in the principles of surgery in order to properly and safely conduct a case of labour. It is entirely due to the fact of the discovery of pathogenic organisms and their relation to disease, or sepsis, and to the further discovery, which has made famous the name of Lister, of the means of destroying these organisms, or anti-sepsis, that not only has surgery in general been nearly revolutionised, but also the treatment of the lying-in patient has been made to conform to the rules which govern a surgical case. I do not wish to be understood, however, as advocating that the same elaborate and necessary details of antiseptic surgery should be followed out in a case of normal labour as is required in a laparotomy or an amputation, except as relates to the attendant himself and to his instruments. Here the minutest detail of personal cleanliness in its broadest sense, and of disinfection of his instruments, are not out of place, and should be conscientiously carried out. But with regard to the patient, being surrounded by the proper hygienic and sanitary conditions, she is then free from all ordinary dangers of infection—that is to say, she is in an aseptic condition, and hence does not require the application of antiseptic treatment beyond what is essential as a matter of cleanliness. Carried beyond this point, it renders us liable to the charge of meddling midwifery.

It is from this point of view, from the close relationship which exists between midwifery and surgery, that I propose this evening to consider the length of time which the patient who has just borne her child should be under the authority of her attendant for the double purpose not only of recovering from her present illness, but of having that recovery so complete and thorough that it will be permanent, and not the starting point of an endless sequence of pelvic disease.

To this end, I shall first briefly review so much of the changes which follow parturition as is involved in a proper consideration of the subject.

The patient, at the close of the third stage of labour, at which point the lying-in period begins, has lost one ninth of her weight at term. As a result of the intense pain, the muscular efforts, loss of blood, and mechanical injury, she undergoes a certain degree of shock which may vary in intensity from being scarcely appreciable in one patient to a fatal condition in another. Her temperature at first rises, then falls

to normal, or may sink below normal if the shock be very severe. The pulse becomes considerably slower—a fact which has attracted much attention and has been variously explained. The blood itself is more hydramic and more fibrinous, and the secretions, notably those of the skin, are much increased. This state of affairs—namely, the shock due to the impression made upon the central nervous system, the reaction, the sudden transfer of developmental energy from the uterus to the breast, the contraction of fibres, and closure of vessels in the uterus, and finally the absorption of serous exudation, œdema, &c., which had previously existed—all make up a series of changes which occupy the first three days, and constitute, according to Barnes, the period just preceding that retrograde process in the uterus and associated structures familiarly known as involution.

The most interesting process in the uterus has been studied in Heschl, whose views have been accepted by the majority of modern writers. He regards it as a retrograde metamorphosis due to a fatty degeneration of the muscular fibres which begins about the fourth day. The regeneration process consists in the formation at the periphery of nucleated cells, developing into muscular fibres, and continuing thus until the close of the eighth week, when the process is complete.

This view is opposed by Sanger and Dittrich, who regard the fatty degeneration as merely incidental to nutrition, and describe the process of involution as consisting of a shortening and narrowing of the hypertrophied muscular fibres until they have reached their primitive size. The gross appearances of these changes are seen in the diminution in the size of the uterus from a weight of two pounds and a half at delivery to one pound at the end of the first week, twelve ounces and a quarter at the end of the second week, and to normal—which is a little more than two ounces—not until the sixth week, this normal being always somewhat greater than the weight of the virgin uterus. It is an arrest of this process at any stage of its course which constitutes subinvolution, a condition immediately associated with inflammation.

Coincidentally with the changes in the uterus are the changes in the no less important structures the supports of the uterus—namely, the ligaments, vagina, perinaeum, rectum, bladder, and pelvic muscular tissues. Any defects in these tissues are as disastrous to future comfort and well-being as a defect in the uterus itself, and their complete involution is just as important. A third factor is the healing of those mechanical injuries to the soft parts produced by the passage of the head through the parturient canal.

Such is the picture presented of our patient at the close of the third stage of labour, and of the various changes which must take place within her before the pelvic organs are restored to their original size and position. This restoration, rapid as it is, it will be observed, requires for its completion a definite period of time—a period which, all authorities recognise, occupies from six to eight weeks. In other words it is a healing process, just as the union of the broken ends of a bone or of the flaps of an amputated stump is a healing process, and, as such, I believe it should be governed by the ordinary laws of surgery. The first law of surgery is rest, and the lying-in period is consequently a period of rest, so intelligently modified and subdivided, that the patient is enabled to emerge from it a perfectly healthy woman.

In carrying out this idea, it has been my habit to impress upon my patient that after the birth of her child she has to look forward to a period of six weeks of convalescence, to be devoted solely not only to getting well, but to getting sound and strong.

This period is conveniently divided into two weeks of absolute rest in bed, one week of alternate rest in bed and moving about the room, a fourth in gaining every day for a time the beneficial effects of sunlight and fresh air, and the last two in resuming gradually the ordinary household duties, with the exception of lifting heavy weights or any other severe muscular exertion. While insisting upon fourteen days in bed, I do not advise a uniform position on the back. On the contrary, I

regard a frequent change of position from one side to the other, and of sitting upright upon the vessel during defæcation or urination, as very necessary, first, for comfort and physical ease; secondly, for overcoming stagnation and hypostatic congestion; and finally, for an opportunity to remove by gravity the clots and other accumulations which, owing to the direction of the outlet in the dorsal decubitus, tend to collect in the vaginal *cul-de-sac*. This plan, carried out with the appropriate treatment, will, I believe, enable us to confidently anticipate a perfect result. Unfortunately, there are two important elements of opposition to the successful implantation of these views. One is the widely divergent opinions held on the subject by equally eminent practitioners; the other is the mass of hereditary and traditional ideas held by the patient herself. Of the latter the most conspicuous is the belief that the ninth day celebrates the close of the lying-in period, and that any length of time spent in bed after this date is so much worse than lost time on account of the weakening effect of the bed. These ideas patient teaching may overcome, not so when there is no unanimity of views on the part of physicians. A careful perusal of the writings upon this subject shows scarcely a precise agreement. While the majority of the text-books dismiss the subject with the general advice to let the patient sit up on the ninth, tenth, or twelfth day, if the uterus has disappeared below the brim of the pelvis, and then to let the patient gradually resume her ordinary avocations, there are a few who emphatically insist upon practically no rest in bed at all, and others who are equally emphatic in the opinion that the patient should remain flat on her back for a month or more. Of these two extreme views, the first has been upheld by Professor Goodell, of Philadelphia, who, in a paper written a number of years ago, on "The Prevention of Puerperal Diseases at the Preston Retreat," stated that the patients were allowed to sit up out of bed the day after delivery, and to repeat this once or twice every day while the bed was being made up, until the fifth day, when they were allowed to dress themselves. He claimed as his reasons for this that, first, labour is physiological and should not wear the livery of disease; second, that the upright position tends to contraction of the uterus and a lessening of the lochial discharge; and, finally, that uterine disease is nearly unknown among savages and those nations which leave the bed early.

This paper of Goodell's, from whom I have been unable to discover any later communication changing these views, attracted a vast deal of comment and adverse criticism. It has been specially considered by Garrigues,¹ who calls attention to the fact that uterine disease is not unknown among savage nations; but, on the contrary, it is very frequent. He quotes Johnson, of Washington, who says that among the negroes of the South, pointed out as remarkable examples of the beneficial effects of early rising after childbirth, he found that these very patients presented themselves more frequently for uterine displacements, hæmorrhages, and the effects of sub-involution, than for any other complaint. The same can be said of our Indian squaws, though there is no doubt that they can, without complaint, endure an amount of pain and disease which would render our more highly organised civilised woman an invalid.

While I believe that there are a very few who coincide with the views held by Goodell, I believe still fewer hold the opposite extreme view—that if one week's rest is good, four or five are better. An instance of this is found in the advice given by Wood,² who evidently looks upon parturition as a most disastrous proceeding. He declares that the patient should be kept in bed on her back for four weeks, and should not at any time assume the upright position. At the end of the fourth week an examination should take place, and any lacerations, cervical or otherwise, which may exist, be repaired. The vagina is then to be packed with compresses for the support of the uterus until the eighth week, when the patient is dismissed, to return for a monthly examination until a year has elapsed.

I have said that two weeks should constitute the length of time that our patient ought to remain in bed, and that the third week should be devoted to alternate moving about the room and resting upon the bed or a sofa. The uterus at the close of the second week weighs somewhat more than twelve ounces, which is five times greater than normal, and should, consequently, not be regarded as yet in fit condition to undergo

the strains and pressures put upon it by a resumption of household duties. It is, however, entirely contained within the bony pelvis, supported in its proper position by the soft tissues which surround it. These supporting tissues—which are made up, as has been said, not only by the ligaments, but by all the muscular structures within the pelvis—should now be the ones to receive attention, and be given the opportunity for development.

They require for this purpose a certain amount of functional activity, having reached a point where any further physiological rest would probably lead to an atrophic rather than to a developmental condition. This corresponds to the principle recognised in passive motion as applied to a limb after a fracture or a dislocation. The third and fourth week of the puerperal state, therefore, represent a developmental period following one of physiological rest, with the additional factor, during the fourth week, of promoting by out-door air and gentle exercise the general health and nutrition of the patient.

Having reached the close of the first month, there remain two weeks before the uterus resumes approximately its natural condition. The patient should by this time feel in perfect health, and should have no symptoms referable to the pelvic organs. The uterus is still, however, a trifle enlarged, the supports still lack their full strength and tone, and it is at this time that any extraordinary muscular exertion—as of lifting heavy weights, climbing stairs, or other hard work—may result in endless mischief by stretching the ligaments and displacing the supporting structures. By impressing this fact upon our patient, there should be no difficulty in securing from her the resolution to avoid all severe muscular exertion during these last two weeks, and to engage in only the lighter household duties.

A faithful adherence to this period of convalescence, combined with a proper and appropriate conduct of the case, will, I am confident, except in the presence of extraordinary complications, yield the gratification of seeing in our patient, one or ten years later, a woman free from the so frequent evil consequences of childbirth.

TATTOOING AND ITS SUCCESSFUL REMOVAL.

By A. H. OHMANN-DUMESNIL, M.A., M.D., Professor of Dermatology and Syphilology in the St. Louis College of Physicians and Surgeons; Consulting Dermatologist to the St. Louis City and Female Hospitals; Dermatologist to the Alexian Brothers' Hospital, Pius Hospital, Polyclinic and Emergency Hospital, &c.

TATTOOING is a practice which seems to be almost universally disseminated on the globe. Among savage tribes and nations it is a species of totemism indicative of the particular tribe to which the individual belongs, or it is a mark of rank, according as the figures are distributed and the manner in which they are made. The process consists essentially in introducing, by means of some sharp instrument, India ink, cinnabar, or indigo into the skin, thereby producing an indelible mark which to all intents and purposes persists during the lifetime of the subject of the process. While there can be no doubt as to the dissemination of the custom, there does seem to be some question regarding its antiquity. A search through literature shows it to be very ancient indeed, going back to prehistoric times. Traditions are extant which purport to allege for it a Divine origin. Be this as it may, there is no doubt whatever that it is a very ancient custom.

A classification of tattoo marks has been attempted, and various authors have given varieties and divisions thereof, which may be all included in the following general divisions:

- I. Ornamental.
- II. Symbolic.
- III. Amatory.
- IV. Obscene.
- V. Miscellaneous.

In the first class we encounter the largest number of cases. We find included in the examples presented all those savages devoid of clothes who are impelled to adorn their bodies with some designs, under the idea that it lends beauty or grace to have these tattoo marks. There exist also a certain number of civilised Caucasians who have a certain morbid desire to have a decoration of some sort or other tattooed upon the skin, looking upon the matter as an ornament. We find examples of this in the form of rings, bracelets, stars, decorations, &c. In the latter class it is usually during early youth or adolescence that the practice

¹ Garrigues. "Rest after Delivery," *American Journal of Obstetrics*, 1880, p. 840.

² W. B. Wood. *New York Medical Journal*, 1890, vol. lii., p. 126.

is most generally indulged in, mature years showing completely the foolishness of such practices.

The second class, or the symbolical form, is perhaps the most widely disseminated of all. Among savages it is not uncommon as a badge of authority or chieftainship. The principal and petty chiefs of every tribe have each one his peculiar mode of marking the body or face or both, and can be easily recognised by this tattooing. It is to the savage what the uniform and insignia are to his civilised brother. In addition to this, it is adopted by many as a "totem," and is one of the most common forms of "totemism" which we have. The peculiarity of the tattooing indicates very clearly the tribe to which the bearer of the marks belongs, and, as it is practically permanent, a renegade can be very easily traced. Among civilised nations we find that symbolical tattooing is most common among sailors. Soldiers are perhaps next in frequency, and after them we find the various trades and occupations represented. Among sailors nautical emblems are naturally in the ascendant, from a simple anchor to a full-rigged man-of-war. They also are profuse in the number of designs which they carry, this being frequently so great as to cover two-thirds of the integument. So far as the other members of this class are concerned, we do not find such a large number of subjects represented, although almost every occupation has its symbolic attributes tattooed.

In the third class we find a large representation. The most common amatory emblems are without doubt hearts, wreaths, initials, and true lovers' knots combined in every manner imaginable. Sailors are very prone to have these, and prostitutes are particularly favourable to them. The latter class is not always satisfied with initials merely, but the full name is frequently demanded. Mottoes of an amatory nature are also favourites, as well as terms of endearment, with or without accompanying initials. For a time it was quite a fad for respectable young ladies to have the initials of their *fiancés* tattooed upon the instep or some other equally inconspicuous place; but the disadvantages accompanying this custom when a match was "broken off" became so apparent that the custom was discontinued.

So far as I have been able to ascertain, the obscene variety of tattooing seems to be limited to two classes—soldiers and criminals—the practice being more prevalent among the former. All the most indecent and obscene pictures, mottoes, sentiments, and designs imaginable are represented. Nothing seems too lewd or debauched for these individuals to carry upon their persons in the indelible characters conferred by tattooing. Of course there are individuals outside these classes who also carry analogous markings, but they are so few in number as to make but a very slight proportion of the whole.

In the last class may be included all those tattoo marks which represent nothing in particular, and whose origin may be traced to an imitative desire, or to no particular reason. It is a noteworthy fact that many individuals possess tattooings who are unable to give any reason for their existence, alleging as a cause simple "cussedness." The designs in these cases are varied, being sometimes two or three dots, an anchor, a letter, or something similar (occasionally the individual's name or initials), but, as a general rule, very limited in extent.

While the classification given above is general in character, it must not be supposed that every case seen will strictly conform to a type. We not infrequently find two types commingled, such as the symbolical and amatory, ornamental and symbolical, amatory and obscene, &c. As an ethnological study that of tattooing is perhaps as interesting a branch as any other, casting as it does much light upon habits, customs, and individual peculiarities.

So far as the extent covered is concerned, we find that savages are more prone to have large areas tattooed than the civilised. A possible exception might be made in regard to a sort of professional tattooed subject which is now fast disappearing. Captain Costentenus, a Greek, was exhibited some years ago as the most extensively tattooed human being living. He was literally tattooed from head to foot, his eyelids and the interior of his ears having been subjected to the process, not to mention his genitals and his palms and soles. This led to a demand for tattooed men and women for shows, and a number were soon forthcoming, being marked quite extensively for the small sum of fifty dollars, only the visible portions being subjected to the operation. The Greek, however, remains to-day the most remarkable living example of tattooing ever seen, there being not a quarter inch of his body that is not the seat of some figure or part of it.

The methods of practising tattooing vary somewhat. Among the South Sea Islanders the tattooing instrument consists of the serrated edge of a sharp shell which is dipped in the staining liquid and then driven into the skin with a sharp blow. Among northern tribes fish-bones are set in a frame and used in the same manner. Civilised man employs a small bunch of fine needles, varying in number from six to ten or twelve. This is dipped in a solution of India ink, vermilion, or indigo, and sharply driven into the integument so as to penetrate into the corium or subcutaneous connective tissue. When the proper pigments cannot be obtained, charcoal or gunpowder finely pulverised is employed for the purpose. The ultimate effect of India ink, charcoal, or gunpowder is to give a blue stain, whereas vermilion or cinnabar remains red.

In addition to these deliberate methods of tattooing we also have accidental means, which are more disfiguring in their effects. Thus, powder-burns are by no means uncommon, occurring either through carelessness or purely accidentally. Here it is the face and hands which are most commonly affected. Injuries inflicted by mineral coal also result in the same manner, and it is for this reason that we find this particular variety of permanent blue stains most often in coal miners. Millwrights suffer from a somewhat analogous trouble known as siderosis. It shows itself as brownish stains on the hands and forearms, caused by particles of steel thrown off their chisel-hammers as they trim millstones. Drawers of gold wire also have staining of the hands and forearms, caused by puncture of the skin and deposit of minute particles of gold. Every metal whose oxides are coloured is capable of producing its peculiar stains when it is accidentally introduced into the integument.

A question which naturally arises is as to the permanency of these stains. All tattoo marks are regarded as practically indelible. It is true that after a certain number of years they become more or less dim, but their presence can easily be verified. More especially is this true when they have been produced by the presence of carbon, in the form of India ink or gunpowder. Vermilion introduced at the same time as India ink will disappear, while the latter still remains very apparent. Indigo will also disappear almost completely after the lapse of years. I have never seen a clear record of India ink tattooing disappearing completely except in the report of the case of the Tichborne claimant, in which some medical witnesses testified that tattooing could, in the course of twenty or more years, completely disappear. I have had occasion to see tattooing of over thirty years' standing, and it was still, not only visible, but remarkably clear and distinct.

The pathology of tattooed skin is the keynote of the permanency of the condition as well as explanatory of the unsuccessful methods which have been proposed for its eradication. It also illustrates very clearly the rationale of a method, which I propose to give, which is successful, and the reasons therefor. When a section of tattooed skin is examined with the microscope a condition is immediately apparent. It is this: Comparatively large masses of a more or less black colour are perceived in proximity to each other. They vary somewhat in size, but a low power will show them very distinctly. Beyond, the integument again appears normal. The pigmentary masses of the normal coloration of the skin appear not only light in colour, in comparison, but are apparently so insignificant as to elicit comparatively little attention. The large masses of carbon—for such they are—due to the tattooing, are located below the epidermis, scantily in the corium, more abundantly in the subcutaneous connective tissue, and almost always in the lymphatic ganglia as well, although in this last locality they do not make any perceptible show upon the surface of the integument. It is this deep penetration of the particles of carbon and their imprisonment in the interlacing meshes of connective tissue which renders their presence practically permanent. The change of colour from black to blue is easily explained. That portion of the carbon which is enclosed in the epidermis appears black, but it is thrown off in a short time, leaving behind it the particles situated deeper in the skin. The transmission of light through the epidermis gives them a bluish appearance, as it does to all black substances located in that portion of the integument. The reason that cinnabar (vermilion) tattooing does not last so long as that of India ink is that it is not so diffusible and does not become enmeshed in the lymphatics so rapidly, if at all. In addition to this, cinnabar undergoes more or less chemical change and finally becomes absorbed, whereas carbon, the active colouring constituent of India ink, coal, gunpowder,

&c., is unaltered and remains *in situ*. This is but a brief summary of the pathology, but it is sufficient to indicate the character of the condition which is to be dealt with in the treatment. It is certainly sufficiently clear to satisfactorily demonstrate the futility of any attempts at treatment wherein the structures of the epidermis alone are involved and the absolute necessity of dealing with the corium and



Tattooing on a woman's arm.

subcutaneous structures to a limited extent, and in such a manner as not to produce scars or other losses of tissue so extensive as to result in scars or other permanent deformities.

The treatment of these apparently indelible marks is, perhaps, not the least interesting part of the subject. As a rule, treatment is demanded in cases of more or less long standing, and various methods have been devised which are, as a rule, unsatisfactory in their results or leave scars which are worse looking than the original stains. The surgical measures employed have all proved failures. The actual cautery, the galvano-cautery, the knife, the sharp spoon, and electrolysis, in order to be effective, have brought about such a destruction of tissue as resulted in ugly scars of greater or less extent. The same may be said of the various caustics, so that it became apparent very early that these methods would have to be abandoned. A method was then suggested for powder-burns, immediately after their occurrence, which was fairly successful. This is the well-known biniodide-of-ammonium and hydrochloric-acid process. Unfortunately, it is but partially successful, resulting in failure in many instances. Following this came Variot's treatment, which is said to be successful, but of which I know nothing from actual experience. It is a rather complicated process, and, from its description, it must be very painful and entail quite an amount of disfigurement for the time being, besides subjecting the patient to the possibility of acquiring scars. The method which I propose to deal with is one which, it is alleged by Dr. Dupuy, originated with natives of the Indian Archipelago. However that may be, it is one which is certainly good, so far as the original idea is concerned, but which I have only found a success by using a particular preparation to carry it out.

The method may be briefly outlined as follows:—The tattooed part from which it is desirable to remove the markings is, first of all, carefully washed with soap and water, then a bunch of needles, previously prepared, containing from six to ten very fine cambric needles, tightly wound with silk thread, is dipped in glycerole of papoid and driven with a sharp blow into the tattooed part. This is repeated over the entire stain. In fact, it is a tattooing with the glycerole of papoid. It goes without saying that this tattooing must be thorough or but an imperfect

result will be obtained on account of the depth at which the pigment is found. I have found it necessary, as a general rule, to go over certain parts a second time in order to obtain a good effect. A peculiarity in reference to this is that the process does not bring about the swelling or inflammatory reaction observed in tattooing with India ink or other pigments. This is probably due to the fact that, in the first place, the glycerole of papoid is not so irritating; and, in the second place, no buccal mucus is mixed with it, a habit which is not only filthy, but dangerous, inasmuch as it may transmit syphilis, as has been observed in many instances. Not only this, but the micro-organisms of the mouth may act deleteriously by inducing septic conditions of greater or less virulence.

The rationale of the method is one which appears to me to be about as follows:—The digestive principle of the papoid is disseminated about the deposit of pigment, thus liberating it. A portion is absorbed, in a finely divided state, by the lymphatics; another part probably finds its way into the upper layers of the epidermis and thence to the surface. In this manner we obtain a disappearance of the pigment. The glycerole of papoid is the only agent which I have found to act satisfactorily in this condition. I have tried solutions of papoid made extemporaneously, and they did not procure good results, although the powdered papoid, mitigated with some alkaline powder, has acted very satisfactorily in old and indolent ulcers. Papain and papayotin made into solution have also proved complete failures in the treatment of tattoo marks in my hands.



Cross-section of tattooed skin.

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A CASE OF UTERINE INERTIA AND CONGESTION (SUB-INVOLUTION).

By HENRY G. MACLAGAN, M.B. &c.

[An Original Article specially written for MEDICAL REPRINTS.]

On April 15th, 1893, I attended Mrs. — in her confinement. She was a thin sallow-complexioned woman of twenty-three years of age, and this was her first child. I was told that previous to her becoming pregnant for this the first time, she had always suffered more or less from profuse menstruation; sometimes so profuse and long-continued as to completely prostrate her for a week afterward.

The labour was natural but rather lingering, lasting altogether rather more than twenty-four hours. Immediately after the birth of the child a tendency to free bleeding showed itself. The uterus, however, responded fairly well to stimulation by compression and kneading, and after giving a full dose of ergot, I was able to leave her in safety. A mixture containing ergot and quinine was ordered to be taken three times daily for a week afterward; but although there was no return of the flooding, the discharge remained free and reddish in colour for much longer than is usually the case. Afterpains were severe, but throughout the progress of the case there was no rise of temperature.

On the 24th of May I was called in again. I found the patient very white and exhausted. She told me that "her courses had come on again two days ago," and were even more profuse than had formerly been the case.

I ordered an eight-ounce mixture, containing four ounces of the elixir caulocorea. The result of two or three one-ounce doses of this medicine was almost immediately apparent. The next day the discharge was much lessened in quantity, and the patient felt very much easier. The day after she was quite well.

The same mixture was ordered to be taken three times daily a day or two before the expected time of the next period. This has just passed, and has been nearer the normal and attended with less inconvenience than any she has had for years.

The retarded involution of the uterus, of which the metro-rhagia was, no doubt, a manifestation, is not so common in first pregnancies as it is in multiparæ. In this case the amount of milk secreted was so scanty that the attempt to suckle the child was abandoned. Perhaps the absence of the normal afferent impulses from the mammae and nipples was in some measure responsible for the defective involution of the uterus. The beneficial action of the Caulocorea was marked in comparison with the ergot previously administered.

THE INTERNAL USE OF HOT WATER IN THE TREATMENT OF DISEASE IN INFANTS.

By H. S. McCONNEL, M.D.

I was called one morning to see a three-months' old, bottle-fed child, and found it in convulsions. It was emaciated, and the convulsions were evidently due to the non-assimilation of its food. Previous to this, with the exception of a slight irritability of the stomach and bowels, it had appeared perfectly well to the parents. When the convulsion ceased, it commenced to vomit and purge. It could retain no kind of nourishment—not even cold water, and medicines did no good. As a last resort, I ordered all the hot water it would take, given through a feeding-bottle, and nothing else except a chloral and bromide mixture when the child was threatened with spasms, several of which it had since I was first called. This was continued for twenty-four hours without any nourishment, the surface being sponged every two hours with cold water. It vomited the first bottle of the hot water, but retained the second, and had the most peaceful sleep it had had for a long time. The condition of the bowels gradually improved, and vomiting gave very little trouble. At the end of another twenty-four hours a tea-

spoonful each of cream, lime water, and water was given every hour, then egg-water, and, finally, condensed milk. This was an extreme case, everyone expecting the child to die; yet it made a good recovery.

Another child, five months old, that had suffered from intestinal pain from birth, crying almost constantly unless it was at the breast, had cried so long and loud one night that it had no voice in the morning, and the parents were almost frantic. It had some fever, the lungs were slightly congested, and the bowels were hard and tender. I ordered poultices and gave large doses of an opiate, but it cried on. It refused the breast, and did not like cold water. After a battle of ten hours, I had the parents get a feeding-bottle and fill the infant up with hot water. He took it as if this was the very thing he had been crying for; he took it eagerly, and in large quantities, and it gave him almost instant relief. He took little else for thirty-six hours, and it was the most important article of diet for one week. Since that time the child has had an acute attack of vomiting and purging, and we resorted to the hot water, with the most happy effect.

Another child, five months, old that was well nourished, yet was crying all the time except when at the breast, was given hot water between feeding periods, and the remedy cured it completely, after paregoric, &c., had failed to give relief.

The importance, in all gastric and intestinal troubles in adults, of rendering the entire alimentary canal aseptic—"making it sweet and clean"—is now almost universally acknowledged, and the results from this method of treating these frequent and distressing diseases have been so satisfactory, that it determined me to apply it in similar affections in infants. Theoretically, nothing could be more rational, and practically the results have been beyond my most sanguine expectations. When a child is vomiting and purging, when its very life seems to be oozing away, there is an irresistible temptation to support life by giving nourishing food, yet experience has taught us that all food acts as an emetic or purgative, and if it do not so act it is useless, the assimilative functions are all suspended, and secretions and excretions are perverted. Hot water here is a stimulant, an antiseptic, a sedative, and a food. Water will support life for a time; transfusion of saline solutions has rescued individuals from the grave, and if you will flush the stomach of the vomiting and purging infant with hot water for twenty-four hours, withholding all foods, and then, in small and easily digestible quantities, at short intervals give nourishment, you will very often rescue it from the grave. I commence with pure hot water, then add salt, and, when necessary, sugar. One will be surprised to see how greedily the children drink it, preferring it to the breast, and it will produce a quiet, peaceful sleep, and the extremities, that were previously cold and clammy, will become warm and natural. The above are only a few of the cases in which, and to which, it is adapted; in fact, there are few diseases of infancy in which the use of hot water will not prove a valuable aid. If my experience and remarks shall induce some to give hot water a fair, full, and impartial trial, I know what the verdict will be, and I shall consider I have not written in vain.

VARICOCELE.

With a Report of Nineteen Radical Operations.

By B. MERRILL RICKETTS, M.D.

[Read before the Cincinnati Academy of Medicine.]

VARICOSITY of the spermatic vein, especially the left one, is quite a common occurrence. There are many reasons assigned as being the cause, but I think the most plausible one is its anatomical relation to the rectum, and the influence of fecal masses pressing upon it. These varicose veins increase both in number and size until they become greatly distended, and hold great quantities of venous blood when their possessor stands erect. There is a sensation of weight, producing great discomfort at times, and occasionally sharp lancinating pains. The scrotum becomes redundant, and in a few cases extends almost to the knee. I myself have seen three that reached to the lower third of the thigh. In cases of long standing, the pressure upon the veins is sufficient to produce atrophy of the testicle, thus necessarily destroying its usefulness, so that the operation is not always the true cause of sterility.

From time immemorial various operations have been resorted to for the purpose of destroying these veins, and preventing return. One of the first was the subcutaneous operation, which is now performed but by a few

surgeons. Among this number is Dr. Edward L. Keyes, of New York, who seems to be satisfied with the results. He believes it the ideal operation, claiming for it less suffering, less loss of time, with greater dispatch, and absence of danger to either the testicle or the patient. I think I am safe in saying that the principal reason for the operation going into disrepute is the great danger of the spermatic artery being destroyed, for surely an operator cannot follow the point of the needle with his eye. It must necessarily be done with the sense of touch. Then the injections of quercus alba, carbolic acid, tincture of iodine, perchloride of iron and permanganate of potassium have all been thoroughly tried and found wanting. They were injected into the veins for the purpose of producing an acute inflammatory process which would destroy their walls. I do not believe that two per cent. of those operated upon ever experienced radical results. These injections are attended with great risk of abscesses, phlebitis, and constitutional disturbances of a dangerous nature; then the remaining ninety-eight per cent. of all the patients operated upon experience greater trouble after these injections than before. I have recently operated upon four of these subjects who had been treated with the injections of iodine and quercus alba. In each case there were hard masses of veins which had not been absorbed and around which the smaller ones had become greatly distended, so that I am thoroughly convinced of the fallacy of this operation.

Within the last ten years the radical operation, which consists of the removal of these veins *in toto*, has been adopted. To my mind this has been the most rational means of destroying varicosity of the spermatic veins; consequently it was not until this radical operation of ligating and cutting *en masse* was introduced that I was willing to adopt operative procedures for the relief of varicocele.

Of the nineteen operations that I have done there has been the loss of but one testicle. Here the varicosity was extensive, and the testicle of not more than one-third the size of its mate. The operation resorted to was double ligation of the mass at points about half an inch distant, its removal, and bringing the stumps together with silk. This was done under the influence of chloroform, and the recovery was uninterrupted, except for a slight rise of temperature, which lasted for three days.

I have done the operation in the following ways:—

1. Single ligature without cutting.
2. Double ligature without cutting.
3. Double ligature with one incision between.
4. Double ligature with the removal of the intervening mass.
5. Ligating the veins separately.
6. Clamping the veins and applying the cautery.
7. Median amputation of the scrotum (lower portion).
8. Lateral amputation of the scrotum.

So that I feel that I am prepared to choose from these operations the one most desirable to do and the one most beneficial and with least loss of time to the patient. I have used both silk and catgut ligatures, and am now free to say that I prefer the latter to the former, although I have occasionally observed slight suppuration with the catgut. I have not yet been able to do the operation with silk ligatures in such a way that they would not sooner or later work their way out; so that I would not do the operation with silk if the catgut could be had. In three cases I have had the temperature go as high as 102° F., and range from that to 101° for three or four days, and then gradually and rapidly subside. There have not yet been any unpleasant complications arising from the operation, although in three or four cases it was three months before the silk ligatures escaped. I have thought within the last year that the ideal operation would be to clamp and cauterise the varicosities, as is done in hæmorrhoids about the anus, and upon the suggestion of Dr. F. W. Langdon this has been done; but I find after doing the operation that it is thus far unsatisfactory. I shall, however, resort to it again and see if the fault does not lie in myself more than in the means adopted.

The operation that I have now decided upon and would most earnestly advocate is to inject a solution of cocaine in the field of incision, cut down upon the veins, apply two catgut ligatures half an inch distant, divide with a knife, and bring the stumps together with a single catgut suture. The parts are then returned and the external wound closed by continuous catgut or silk and dressed with boric acid. I do not now find it necessary to administer an anæsthetic of any kind to produce unconsciousness, having found that injections of cocaine will enable a painless operation to be done.

THEORY AND PRACTICE IN THE TREATMENT OF SYPHILIS.

[We print below two strikingly contrasting views of this subject. The opinions in the left-hand column are those of two first-class American medical journals, whose editors appear to take a sufficiently gloomy view of the prognosis. In one of these the opinions and practice of two eminent French syphilographers are quoted. Dr. Geo. W. McDade, whose opinions are printed in the right hand column, was, when a young practitioner, singled out for eulogy as a most intelligent and accomplished man of science by the late Dr. Marion Sims, and is the originator of a treatment of syphilis on behalf of which he is able to advance the remarkable claim that if it is adopted at once secondary symptoms seldom follow the primary infection. Though at first received with natural incredulity, this is supported by evidence in a number of cases in England and America.—Ed. MEDICAL REPRINTS].

TREATMENT OF SYPHILIS.

From the "Medical Mirror."

There are many points which suggest themselves daily to the busy practitioner with reference to the victim of syphilis, such as the proper advice with reference to matrimony; the length of time since evidence of the constitutional condition has presented itself before marriage is allowable, and the proper course to pursue in the matter of treatment, from the beginning. There can be no doubt that the constitutional treatment should not be administered immediately following the primary lesion. Full opportunity should be given for a secondary expression, in order that the diagnosis be definitely made. It is better for the secondary expression to be pronounced, in order that the patient may be properly impressed with the importance of prompt, thorough, and continued treatment. If the diagnosis be in doubt or if the secondary expressions be mild, it is often quite difficult to impress the patient with the serious importance of continued treatment. The question may well present itself as to whether if we modify or mitigate secondary manifestations by the too early administration of remedies, we do not interfere with the best good of the patient.

In this disease, as well as in many others, it is possible that the virus exhausts itself sooner if given full play in the beginning. There is much reason to believe that the modification or mitigation of the early stages of this disease in particular interferes with its prompt subsidence or elimination.

How long shall the treatment be continued? When shall we desist? When shall it be taken up again? are all questions which often present themselves to us.

From the "Medical Bulletin."

This is one of the most interesting, and, as is well known, most disputed ques-

TREATMENT OF SYPHILIS.

By Geo. W. McDade, M.D.

SUCCUS ALTERANS stimulates the secretions throughout the entire system, acting directly upon the stomach, liver, kidneys, and the glandular system. The appetite and digestion are improved, and there is an increased flow of saliva, gastric fluids, bile, urine, and perspiration.

Secondary symptoms seldom follow the primary stage if SUCCUS ALTERANS is promptly and persistently used on the very first appearance of the chancre. Secondary cases are usually discharged from treatment in three or four months, and tertiary in from four to eight months. This is the rule; of course there are exceptions, owing to idiosyncrasies of the patient, amount of constitutional disturbance, condition of patient, and the length of time since contracting the disease. Some are cured in less time, while others require more. I have never had to extend the treatment into years. After all evidences of the disease are subdued, I recommend the patient, as a precautionary measure, to take the medicine every alternate week for several months. No injurious effects are produced, even if it should be continued for years.

Patients who have been treated on the old plan usually improve rapidly after taking SUCCUS ALTERANS, and soon recover from any bad effects the mixed treatment may have produced. 1

tions of medical practice. The physician is often puzzled in making a proper choice, and in the end, and after much hesitation, generally decides upon what, in his experience, has been the mean duration of treatment. But how often do we see patients who, after having been under medical supervision for a length of time, abandon the doctor to treat themselves—believing to have a sufficient experience to permit them to do so, and thus destroy their constitution by a too-prolonged use of mercurials, when the latter are no longer indispensable, yea, often even harmful.

In a communication to the Paris Société de Thérapeutique, Dr. Bontemps, of Saumaz, supported the doctrine of Prof. Fournier, who asserts that in no case can the duration of the anti-syphilitic treatment be fixed at less than three or four years. As at the same time, the patients ought to observe in the medication certain alterations and periods of repose or dishabitation, Dr. Bontemps has arranged the following table, a convenient *vade-mecum* for the practitioner:

First year:

- 6 months of mercurial treatment.
- 3 months of potassium iodide.
- 2 months of repose.

Second year:

- 2 months of mercury.
- 5 months of iodide.
- 5 months of repose.

Third year:

- 2 months of mercury.
- 5 months of iodide.
- 5 months of repose and sulphur baths.

Fourth year:

- No mercury.
- Potassium iodides, with intervals of repose and sulphur baths.

think *SUCCUS ALTERANS* the best remedy for the cure of mercurialism and iodism.

The *SUCCUS ALTERANS* sometimes produces temporary nausea; further gastric disturbance I have never witnessed. Almost invariably the appetite and digestion improve after taking the *SUCCUS ALTERANS*. There is also abundant evidence of its value in anæmia from either syphilitic or other causes.

I am convinced of its curative effects, eradicating the syphilitic spores from the blood; also increasing the number of red corpuscles.

Mercury and the iodides, long continued, often produce injurious effects upon the system, second only to the disease itself. As before stated, *SUCCUS ALTERANS* can be taken for an indefinite time without injury. My mode of administration, as with any other remedy necessary to be continued for any length of time, is to occasionally discontinue it for a few days, or a week, alternating with tonics or other medicines, as are indicated; each return gives renewed benefit.

The usual dose of *SUCCUS ALTERANS* is a teaspoonful three times a day, gradually increased to tablespoonful doses, taken in water or syrup, either before or after eating.

GEO. W. McDADE, M.D.

THE TREATMENT OF SPRAINED ANKLE.

By P. C. BARKER, M.D.

AMONG the minor surgical ailments that we are called upon to treat, sprains about the ankle joint are perhaps more frequently encountered than any others. As they are generally treated, they are also more painful and more lasting than any other minor ailments. Therefore it will not be amiss or unprofitable to reconsider the whole question of sprained ankle, so that it may be ascertained if there is not a better way to treat it than by the method generally pursued—namely, rest and evaporating lotions in the early stage, and a plaster or other immovable apparatus in the later treatment. Let us first recall what takes place when the injury is received. Generally it is the outer side of the ankle that is injured by the weight of the body being suddenly and more or less violently thrown upon the foot while the latter is turned in. The ligaments and other fibrous structures are overstretched and sometimes lacerated. There is an effusion of plastic serum into the surrounding tissues, followed by swelling, heat, and pain. The traumatic œdema, added to the injury to the fibrous structures and the

nerve filaments, produces extreme hypersensitiveness. The victim is not only unable to bear his weight upon the foot, but he is also at the outset intolerant of the most gentle manipulation of it. Rest, cooling lotions, &c., serve to relieve the pain and promote comfort, but they neither reduce the swelling to any extent nor do they relieve the tenderness. Indeed, as time goes on, there seems to be a tendency to new cell formation in the lymph effused, so that in severe cases months elapse before any weight can be borne upon the injured foot, and the swelling only subsides as use is gradually resumed, while tenderness is the last symptom to yield.

That the injury to the structures around the ankle joint when sprained is as above stated, and the treatment thereof, as mentioned above, is in accord with the scanty references to the subject in text-books and treatises on surgery, will not be denied, and, therefore, it is not necessary to extend the length of this article by any quotations from or even references to authorities. The treatment mentioned is the usual and prevalent treatment. Something should be done to arrest the swelling and at the same time relieve the pain. Hot water applied continuously for several hours best meets these indications. Then a carefully applied narrow roller bandage (preferably of flannel), covering the entire foot and ankle, will not only tend to prevent the further effusion of serum, but it will encourage the absorption of that already effused, beside supporting the overstretched or torn ligamentous or other fibrous structures involved. At least once daily the bandage should be removed and deep finger massage practised wherever there is tenderness. This proceeding stimulates the absorbents and gradually relieves the tenderness. The first few times it is practised it hurts infernally in severe cases, but each repetition hurts less and less, so that after a few times the patient can himself rub the tender spots through the bandage and so expedite his own recovery. From the very outset the patient should be required to use the foot as much as he can without great pain. This improves the circulation in the foot, and is therefore of service. If these details are carefully and thoroughly carried out, the average uncomplicated even if severely sprained ankle can be entirely cured in three or four days.

Many years ago (about 1864) the writer sprained his ankle. The swelling was excessive and the tenderness so great that the foot could not be allowed to rest upon the floor. Previous reflection had satisfied him that the usual treatment of this injury was not based upon correct principles, and, having a favourable case of his own to experiment with, he determined to employ the treatment under consideration. The foot and ankle were first placed under a stream of cold water for half an hour, then rubbed vigorously and bandaged. Several rubbings were necessary before this part of the treatment could be self-inflicted, the pain was so great. For one day it was necessary to use a crutch, the next day a cane, and on the third day an ordinary boot was worn over a thin bandage. The recovery was practically complete. It was subsequently discovered that hot water was not only more agreeable but more efficient than cold water in arresting the swelling and relieving the pain.

Cases of considerable duration—a week or two weeks—that have previously been treated by the rest method, do not require the hot water, but in other respects they should be treated like a recent case. Many such have fallen under the writer's care. The improvement will not be so rapid as in a recent case, but it will be satisfactory. Last summer a young lady came home from college with a badly sprained ankle that had been in a plaster splint for nearly four weeks. The swelling was still great, and it was very firm and hard, as well as very tender, so that the foot could not be allowed to even rest on the floor when the splint was removed. It was thoroughly rubbed, twisted gently in every direction, and then carefully and snugly bandaged with a narrow flannel bandage, so as to cover the entire foot. After the bandage was applied she could bear a little—a very little—weight upon the foot. She was shown how and where to rub the foot and ankle herself, and directed to do it often, meantime using it as much as possible. The thorough rubbing was done by myself but once daily. In a week she could walk without crutch or cane, but the swelling had not subsided, and only a large slipper could be got on. Before the second week elapsed, however, the young lady walked as well as ever.

Conclusion.—The treatment consists in—

1. The prolonged use of hot water.
2. Careful finger-tip massage.
3. Bandaging with flannel bandages (of entire foot).
4. Use.

MEDICAL OPINION UNANIMOUS.

BRITISH MEDICAL JOURNAL.

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

JULY 15th, 1893.

DR. FRANK KRAFT, of Cleveland, writes in the *Medical Advance* on wine, women, and song, with special reference to their therapeusis. Dr. Kraft finds that excesses in wine, or rather in alcohol, breed three kinds of drunkards, each of which is best set up by certain remedies. These are his three pharmaco-clinical types: "Nux vomica for the beer drunkard; gelsemium for the 'champagne' drunkard; and

sulphuric acid for the whisky drunkard." It appears from this that the hard drinker has not only to make an intelligent diagnosis of himself, and then fill his pockets with a bottle of sulphuric acid, nux vomica, or sempervirens, as the case may be, in order to keep in good condition.

"Woman," Dr. Kraft thinks, "has caused man considerable trouble," and this cautious estimate of social history will not be generally disputed. We turn with some interest to find the drug which solaces man when he has had embittered experiences. Hyoscyamus we find is suited to relieve a disappointment in love so severe as to make the victim turbulent, talkative, and irritable. Henbane quiets the noisy lover. Belladonna helps the moody, sleepless, and dangerous man. Let the ladies take notice and reject their suitors, not with a promise of continued sisterly interest, but with vials of the proper antidote. Nux vomica is for the passionate, sensual fellow who loves not well but for amorous ends, while staphisagria cures the man who is simply humiliated and mortified at his refusal. If disappointment in love makes a man swear, give veratrum, says Kraft; "if it makes him lie, give anacardium, and if it makes him a black-guard, give chamomile. If he is intensely erotic, let him chew camphor."

For the ills that come from song Dr. Kraft does not say much. He is vindictive toward tenors who sing too much, and thinks they may be helped by stramonium. For the ill-effects upon man of the song of others his list is far too short, and includes only natrum mur., followed by sulphur and belladonna. The foregoing is contemporary medicine, though it sounds like a dream-book. As practitioners of medicine we must look upon man and disease from every aspect, and Dr. Kraft furnishes us a decidedly novel and (from one point of view) a very amusing one. But is this science?

TO GENERAL PRACTITIONERS.

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NEWS AND NOTES.

SIR BENJAMIN WARD RICHARDSON, M.D., &c., &c., has been confiding in the interviewer of the *Christian Commonwealth*, a journal much exercised in mind by such diverse matters, one gathers, as the scriptural authority of baptism and the alleged military control of vice in India. The interviewer asked Sir Benjamin if he had faith in any of the alleged cures for drunkenness.

"Oh, no," he exclaimed, "none whatever; in my opinion they're quite impostures. There is no cure for inebriety but total abstinence. Of that I am quite sure. There is no reason to suppose it should be otherwise. Alcohol produces a constitution of its own; it remains long in the body after a man has commenced to be an abstainer, and so long as it is there the craving is there—the desire for itself. There is a sort of mental attraction for it, which goes on until the thing is entirely eliminated from the body; then the taste for it is forgotten, and the body is itself reconstituted out of healthy material. Then you have your perfect abstainer, and even he is not so sound as a person who has never from the beginning of his life taken alcohol."

"I remarked," continues the report, "on the growing tendency to treat confirmed drunkenness as a disease. Dr. Richardson responded:

"Drunkenness is a disease. I would isolate such cases at

infected water was kept in the dark when it was found that a slight multiplication of the bacteria had actually taken place. Diffused daylight (not direct sunlight) had a marked destructive power on the bacteria after an exposure for several hours.

From these results the authors are led to the conclusion that the purification of natural water is chiefly accomplished through the influence of the sun's rays. The practical suggestion, based upon the above results, is that sewage should be exposed to sunlight before being poured into rivers or other water courses. In the exposure (they say) it should be placed in shallow basins lined with white cement, when it would doubtless present a pleasing spectacle to the observer, though one doubts its complete and permanent sterilisation in the process.

* * *

THE daily press, a somewhat uncertain authority, gives currency to the news that Dr. Kitasato, of Tok'ō, has actually succeeded in curing consumption in advanced stages by means of some new applications of Koch's remedies. The Japanese government has granted 45,000 dollars to Dr. Kitasato for this year, and 15,000 dollars for each of the next two years, to prosecute the study and treatment of cholera, abdominal typhus, diphtheria, and consumption. During the last winter Dr. Kitasato has accomplished some remarkable results with consumption. Four out of five patients who had been treated two months were discharged cured and one hundred and twenty-five who



THE SISTERS' HOSPITAL, ST. ALBANS.

"once. The quicker they leave off the better. I have never seen any mischief arise from making patients abstain altogether straight away. They grumble and complain, of course, and tell you they feel it, and so forth, but I have never in my life known any physical mischief arise from it. Patients are treated as abstainers in the Temperance Hospital. They come to us there with all kinds of diseases; we have quite as many non-abstainers as abstainers, and I never find any difficulty. I have just published in *The Asclepiad* a lecture on the first 200 cases under my care. I never found a single patient who asked for stimulant."

Perhaps it would require even more than the hardihood of the customary hospital patient to call on the apostle of non-alcoholic medication for a drink. The rest of the "interview" meanders pleasingly among such topics as cycling, the smoke nuisance (not tobacco smoke, *bien entendu*), model slaughter-houses, and pure water.

* * *

THAT sunlight has a more or less powerful effect upon bacteria has been known for some years. A couple of German doctors have now systematically investigated the influence of light upon bacteria floating in water. The more important bacilli with which they worked are the bacilli of typhoid fever and cholera, although many other species were tested. The authors found, by way of experiment, that water containing 10,000 germs to the cubic centimetre became sterile, i.e., freed from these living bacteria, after an exposure for a single hour to the direct rays of the sun. In another experiment similarly

had been in hospital only a few weeks showed marked improvement. None of the patients had passed beyond the second stage, nor had cavities formed in their lungs; but all were emaciated and had night sweats, and several coughed sixty grammes of sputum daily. One had been in bed six weeks before being treated. All showed signs of marked improvement within a month. The sputum decreased, and there was gain in flesh. The treatment is a modification of Koch's. A preparation of tuberculin is injected under the skin and taken into the blood. Its effect is to give immunity to healthy lung tissue, and thus enable the diseased portions to recover health. The most noticeable effect of Dr. Kitasato's method is the absence of reactionary fevers, which have followed the use of tuberculin in Germany. In only one case did this fever occur, and then but once. We do not see that Kitasato has done any more than others who have used modifications of the tuberculin.

* * *

THE Society for Promoting the Welfare of the Blind in Russia, which is under the direct patronage of the Czarina, has arranged to send several young ophthalmic surgeons this summer in "flying columns" to various localities which are far removed from skilled assistance. They will do what they can toward the diminution of blindness, of which there is a great deal in Russia, both by treating eye diseases, which, if neglected, might end in loss of sight, and also by operating in cases where it may be possible to restore sight by surgical means. The society is not at present possessed

of sufficient means to carry out this excellent scheme, but it hopes by means of subscriptions to obtain pecuniary assistance for the purpose.

DR. ALESSANDRI, an authority on criminal anthropology, was killed recently by a prisoner in the penitentiary at Civita Vecchia. The prisoner had been shamming illness, and was examined by Dr. Alessandri, who pronounced him a malingerer, and ordered him back to his cell. The man became enraged and stabbed the doctor in the breast with a sharp piece of iron which he had concealed in his coat.

M. FERDINAND DE LESSEPS once stated that all the conquerors of Egypt, from the Hyksos down, had been compelled to loose their clutch on that country because they failed to reproduce their race while in it. This may apply to the French, whose reproductive powers appear to be failing, even in their native land; but it does not affect the English. Indeed, the truth seems to be quite the contrary, for so prolific has the Anglo-Saxon proved in Egypt that childless couples are now recommended to visit the Nile Valley. In one case a bride of twenty years' standing presented her lord with their first child while sojourning in Assouan, in the extreme south of Egypt.

"A FRENCH Surgeon Wanted The Autopsy" (to quote the expressive headline of an American professional contemporary) though he had cured the patient. Professor Gayet, of Lyons, was the surgeon. Having cured the man of an arterio-venous aneurism of the internal carotid artery and the cavernous sinus, and, being desirous that this happy result should be verified after the death of the patient, he paid his patient a certain sum for having tattooed on his arm the following lugubrious words: "Anévrisme artério-veineux du sinus caveux guéri; prière d'autopsier." (Na Cl, gr. i. is the proper digestive to be taken by anyone who can "swallow" this story.)

A MEDICAL VELOCIPED CLUB has been formed in Paris for the purpose of bringing together medical men who use a velocipede instead of a carriage, and thus giving a moral sanction and support to their provincial colleagues. There are already a good number of members.

A MEMBER of a Yale "Eights" crew was recently taken ill suddenly with abdominal pain, vomiting, and other symptoms referable to the appendix vermiformis. A New York surgeon, who had written much regarding that small but important portion of the body, was summoned. As the consultant left the room, the student asked his name. "That," said the nurse, "is Dr. X——." "Good Lord!" said the young man, "then I must have appendicitis." His diagnosis was correct.

THE *Riforma Medica* complains that the number of doctors in Italy is already in excess of the number required, and is continually increasing. Among other large towns, Naples counts a doctor for every 513 inhabitants. The natural result is that the amount of fees which falls to the lot of these practitioners is very inconsiderable. Compared with all the other liberal professions, it would seem that medicine is, from a pecuniary point of view, the least productive in Italy.

IPECAC. is the great remedy for dysentery in India. Dr. E. H. Thomas, of Nagina (*Indian Medical Record*), has found that parched grain powder (*Pulv. cicer. esiccata*) acts equally well, and is a very cheap and effective remedy. It is given in doses of ten to twenty grains, three times a day. From Germany, on the other hand, comes this remedy: R. Solut. acid. boric., four per cent., 4000; acid. tannic., 30; tinct. opii., m xv. M. Sig.:—Use one-fourth as an injection with warm water.

THE USE OF CARBOLIC ACID IN SOME AFFECTIONS OF THE EYE.

By G. HERBERT BURNHAM, M.D., F.R.C.S. Edin.

SINCE Professor Lister has said that he has returned to the use of carbolic acid as an antiseptic on account of its superiority, I now gain courage to affirm the same belief with respect to its position in ophthalmic diseases.

Some years ago I published a paper on the use of carbolic acid in the "Royal London Ophthalmic Hospital Reports," and later on in the *American Journal of Ophthalmology*. It was used with great success in gonorrhœal conjunctivitis and suppurative affections of the cornea of all kinds, in the strength of 1 in 20 and 1 in 40. Owing to the excessive praise lavished on newer remedies of the same character, I had dropped its use for some time. As above stated, however, I do now affirm that the results achieved with carbolic acid have been more satisfactory in every way than those got by any similar remedy. I, of course, am speaking of typical cases that test the respective merits of antiseptic remedies.

AMERICAN OPINION.

OPIUM INEBRIETY.—CASE TREATED WITH CODEINE.

By J. H. KENNEDY, M.D., Aberdeen, Md.

MRS. A., aged thirty-seven, two children, youngest one month old, consulted me September 22, 1892, regarding her opium habit, she having used opium in some form several years.

It was first given when she was sixteen years old by a physician, himself addicted to it, used irregularly, and during the past six years taken steadily, reaching two ounces of laudanum daily.

Her ancestral record was faulty, and her physical condition bad. She told a story of long suffering from articular rheumatism, neurasthenia, neuralgia, dyspepsia, and middle-ear disease. What with her damaged physique and post-puerperal status, the outlook for success in treatment was not brilliant, but it was begun by giving a grain of morphine four times daily in lieu of laudanum, which she could not longer retain. In three weeks this was reduced to four eighth-grain doses a day. Meantime she had taken a triple tonic—quinine, strychnine, and arsenic—with coca wine, and forced feeding of most nutritious food, all of which, however, did not prevent decided reflex reaction.

At this juncture I asked the advice of Dr. Mattison, of Brooklyn, whose experience specially fitted him to give counsel in a case like mine. He gave me prompt reply, and in accord therewith my patient was at once placed on half-grain doses of codeine sulphate morning, noon, night, and bedtime, continuing the tonic and full feeding, with massage and as much open-air exercise as possible without fatigue.

In a week the noon dose of codeine was omitted; in another week the night one; after the third week the morning portion; and at the end of the fourth week that at bedtime. Bromide of sodium, twenty to thirty grains, once or twice daily, was sometimes used, and for the insomnia twenty to thirty grains of sulphonal worked well. The epigastric "goneness" was relieved by a drachm or two of alcohol in hot milk, and for the morphine craving, which at times was marked, nitroglycerine in hundredth-grain tablets on the tongue, hourly, three or four times, was used with success. Improvement persisted, and in seven weeks the patient had gained ten pounds, looked several years younger, and said she felt like her old-time self.

Five months have gone since the last dose of morphine was given, and Mrs. A.'s health is much improved, despite domestic surroundings not well fitted to enhance a good result.

This case was highly unpromising. The patient's physical condition was much impaired, her morale damaged, and her environment not conducive to success; yet against all these drawbacks success was secured.

I am of the opinion that had more time been taken for the morphine reduction, the attendant nervous discomfort would have been largely lessened, and should a similar case present I would make the rate of decrease not more than half a grain, and even less, a week.

There is no doubt that the lowered general health of this patient was a decided bar to rapid withdrawal. *Festina lente* is the rule that should obtain where the inroads along somatic lines are marked: but when the reverse condition presents, total abstinence from opium can be reached and normal sleep secured under the codeine treatment, it is said, in from four to six weeks.

There is no question as to the good of codeine in these cases, and its advent in the treatment of morphinism marks a decided advance in the cure of this disease.

SPONTANEOUS CURE OF A PAPILLOMA OF THE NASAL SÆPTUM.

By JOHN DUNN, M.D., Richmond, Va.

In February, 1891, I was consulted by Mr. W., aged thirty, in regard to a nervous twitching of the right eyelid. In examining the nasal cavities to see if I could find any condition that might serve as a probable cause of this affection, I found on the left side of the cartilaginous sæptum, at its inferior portion, near the floor of the nose, about three-quarters of an inch from the nasal entrance, a papilloma. In size it was about as large as the common white bean. Its surface resembled an ordinary skin wart that had "gone to seed," except, of course, that it was softer and had the pinkish colour that the mucous membrane would naturally give it. Mr. W. had noticed it about three months previously, but, as it gave him no especial inconvenience, he paid no attention to it. It itched occasionally, and would bleed if he rubbed it too hard. He declined to have it removed. In February, 1893, Mr. W. a second time came to consult me. In examining his nose, I found that there was no trace of the papilloma to be seen. I asked Mr. W. if he had had it removed. He replied that, about three months after he had seen me, he was one day rubbing the growth in his nose with the tip of his little finger and the growth "fell off," since which time he had experienced no trouble with it.

Nasal papillomata are comparatively rare. Mackenzie says (*Diseases of the Nose and Throat*, p. 265): "I have met with only five undoubted examples of intranasal papilloma." Bosworth (*Diseases of the Nose and Throat*, Part I., p. 422): "My own records include something over two hundred cases of benign tumours of the nose, but one of which was a case of papilloma." A few other cases have been reported. The point of interest in connection with the above reported case was the spontaneous separation, thereby showing the relation between this form of intranasal papilloma and the ordinary skin warts. And this fact may further explain why so few of these growths come under observation. In Mr. W.'s case there was no apparent accompanying nasal affection which might have acted as a determining factor in the causation of this papilloma. Nor would this case have come under observation had there not supervened an annoying twitching of the eyelid, with which the presence of the papilloma in the nose had nothing to do.

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

INTUBATION OF THE LARYNX.—In reporting the results of two hundred and ninety-one cases of diphtheria, J. Bokai, of Buda-Pesth, recommends highly the use of O'Dwyer's method of intubation. Of these cases, there were one hundred in which recovery followed, although in only eight cases was a secondary tracheotomy resorted to, and only once with favourable results. During the past twenty months intubation has entirely superseded tracheotomy, and the results lead him to believe that intubation is a better practice than tracheotomy. In hospital practice the care of the patients is lessened and easier. One nurse can care for twelve intubation cases, where only four or five tracheotomy cases are possible. He concludes that there are but two classes of cases in which tracheotomy is called for. 1. Where there is at the same time marked pharyngeal stenosis accompanying the laryngeal. 2. Where there is marked oedema of the larynx, making intubation of little service.—*Annals of Gynecology and Pediatrics*.

CHLORAL IN THE TREATMENT OF BOILS.—M. Spen recommends very highly, as far superior to all other treatment, the use of chloral externally in this troublesome class of affections. He directs that the boil be kept covered with a tampon of cotton-wool soaked in the following solution:—

R Chloral hydrat ... 3 iiss.
Aque ...
Glycerin aa ... f 3 v.

Misce.

—*Bull. Gen. de Therap.*

EMPHYSEMA.

R Olei terbinthi... 5 j. iv.
Aq. menth. pip. ... 5 iv.
Sacchari.
Puly. acac. aa ... 5 j.

M. Tablespoonful every three hours.

CARBUNCLE.—The following, says Dr. Buxton Shillitoe, will sometimes abort a carbuncle or boil if applied early:—

R Extract opii ... 3ss.

M. Sig.: Smear thickly over the swelling three or four times a day, then apply

R Pulveris opii ...
Unguenti hydrargyri ...
Saponis duræ aa ... 3ss.

M. Sig.: Apply spread on thick leather.

RHEUMATISM, CHRONIC:—

R Pulveris guaiaci resinæ ...
Potassii iodidi aa ... gr. x.
Tincturæ colchici seminis ... 3ss.
Aque cinnamoni ...
Syrupi simplicis, aa q. s. ad. ... 3j.

M. Sig.: A dessertspoonful to a tablespoonful thrice daily.

—*Philadelphia Hospital.*

CUTANEOUS DISEASES.—Nothing is better, says A. T. Thomson, to allay itching in cutaneous diseases than

R Plumbi acetatis ... gr. xvj.
Acidi hydrocyanici diluti ... 3iss.
Spiritus rectificati ... 3ij.
Aque destillatæ ... 3vij. ss.

M. Fiat lotio.

NEURALGIA.—

R Strychninæ sulphatis... gr. j.
Morphinæ sulphatis ...
Acidi arseniosi aa ... gr. iss.
Extracti aconiti ... gr. xv.
Quininæ sulphatis ... 5i.
Misce et fiant pilulæ No. ... xxx.

Sig.: Take one pill three times a day.

—*S. D. Gross, M.D.*

EARACHE.—The following rarely fails to give prompt relief:—

R Tincturæ aconiti radicis ... 3iss.
Glycerini ... 3ii. ss.

M. Sig.: To be warmed and dropped into the ear.

—*Gerhard, M.D.*

CRAMPS OF CHOLERA.—

R Chloral hydrate ... 5 iij.
Morphia sulph. ... gr. 1.
Atropia sulph. ... gr. 4.
Aq. chloroformi,
Aq. destil aa ... 3 ss.

Sig.: Twenty minims repeated in ten minutes, and then as needed.

—*Bartholow.*

ATROPHIC RHINITIS.—

R Thymol ... gr. iss.
Alcohol,
Glycerine aa ... 3 iss.
Aq. dest. ad ... 3 j.

Use as a spray.

—*Lederman.*

HEMORRHOIDS.—

R Atropinæ sulphat ... gr. iv.
Acid. tannic ... gr. ij.
Morphinæ sulphat ... gr. vj.
Cocainæ hydrochlorat ... 3 ss.
Vaselin ... 3 j.

M. et ft. ung. S.: Apply a small quantity to the hæmorrhoid after each stool.

PERITYPHLITIS patients may be nourished by enemata according to the following formula:

Beef-tea ... fl 3vij.
Eggs No. ... iij.
Peptone (dry) ... 3 ijss.
Sodium chloride ... gr. xlv.

For one injection.

ERGOTININE is recommended by Franck as more prompt, sure, and constant than ergotine. The dose is one two-hundred-and-fiftieth to one one-hundred-and-twentieth. It has been used hypodermatically in a variety of hemorrhagic and other conditions.

DIGITALIS in pneumonia has been tried by Hoepfel in fifteen cases. Large doses decrease temperature indirectly, relieve dyspnoea by increasing the force of the heart-beat, and shorten the attack two or three days. *American Journal of the Medical Sciences*, No. 243.

SALICYLIC-ACID treatment of simple pleurisy is considered valuable and not dangerous by Köster, who got seventeen good results in twenty-seven cases of primary pleuritis thus treated. Fifteen-grain doses, or twenty-two of the salicylate of soda, were given three times daily.—*Ther. Monats.*

LUMBAGO.—Instantaneous remedy.

R. Collodion
 Tincture iodi
 Liq. ammon. (equal parts of each)...

Apply freely over the parts affected with a camel's hair brush and instantaneous relief will be afforded

ASA FETIDA has been found by Turazzo an efficient remedy for the prevention of habitual abortion. The dose is to be gradually increased from two to ten grains daily, and then gradually decreased, but kept up through the whole of pregnancy.—*Centrablatt für Gynecol.*, No. 8, 1892.

PERTUSSIS IN THE ADULT.—Stiller says that he has used pilocarpine for a long time, ten drops of a one per cent. solution three or four times a day, in hiccoughs of a nervous origin, and that it is the best remedy known for this condition.

OTORRHOEA.—Antiseptic wash in the treatment of otorrhea:—

R. Hydrarg bichlor gr. ss.
 Acid tartaric gr. xx.
 Aquæ, q. s. ad. 3xj.

M. Sig.: Wash out the ear first with warm water, then fill the ear with the above solution.

—*Amer. Jour. M. Sc.*

FARADISATION IN ASCITES.—Either of two plans may be pursued in applying the faradic current: One electrode placed on the upper dorsal vertebra, and the other moved over the abdominal wall, so that each group of muscles is acted on, or both electrodes held in one hand, according to the method of Duchenne, and each group of muscles made to contract several times before passing on to the next. Fatigue of the muscles should be avoided, for this indicates that the applications have been too protracted or too strong. The *séances* should not exceed fifteen minutes in duration, and they need not be more frequent than once a day. In some of the reported cases the faradic applications have been made two and three times a day, and with increased rate of improvement; but, as a rule, once a day suffices.—**BARTHOLOW.**

HYDRIODIC ACID SYRUP. Dr. Wilcox says, offers a palatable way of administering iodine; that we can saturate the patient and avoid iodism; and that its field of usefulness is greater than that of iodide of potash.

SALINE CATHARTIC is useful in diagnosing intestinal obstruction. If colic is present it will purge. It may arrest a peritonitis. It will develop and make plain the more serious condition of mechanical obstruction, but must never be given in an undoubted case with the idea of affording relief, for it can only aggravate the condition.—**MUDD.**

PERTUSSIS.—

R. Powdered belladonna root gr. ½.
 Dover's powder gr. ss.
 Sublimed sulphur gr. iv.
 White sugar gr. x.

M. Sig.: Take in one dose from two to ten times a day, according to age of patient and effect produced.

CHLORAL IN ECLAMPSIA.—I believe that we have in chloral hydrate an agent of wonderful therapeutic value for the relief of reflex irritation; and that in the two, venesection first, judiciously, promptly, and boldly done, followed by chloral, if the convulsions continue, we have measures that will never be supplanted by any more perfect or potent.—**AYRES.**

OUR ILLUSTRATIONS.**THE SISTERS' HOSPITAL, ST. ALBANS.**

The picturesque group of buildings shown in our illustration, just opened at St. Albans, and henceforth to be known as the "Sisters' Hospital for Fevers and Infectious Diseases," will supply a long known want in the neighbourhood. The buildings are erected in red brick and tile, varied by facings of Bath stone, in a style adapted from the early English renaissance. The soil is gravel. The grounds are charmingly laid out in lawns and gardens, and the fittings within are in every way worthy of the best modern experience in hospital construction. The work has been carried out for Sir Blundell Maple, the donor of the entire magnificent building and its site, by Mr. Morton M. Glover.

BACK NUMBERS OF MEDICAL REPRINTS.

The following issues are out of print:—

No. 1 (February, 1890).	No. 14 (March, 1891).
No. 7 (July, 1890).	No. 17 (June, 1891).
No. 10 (November, 1890).	No. 19 (August, 1891).
No. 13 (February, 1891).	No. 22 (November, 1891).

Any other back number will be sent post free to any medical man on receipt of three penny stamps.

[For contents of numbers dated earlier than January, 1893, see former issues of MEDICAL REPRINTS.]

No. 37 (February, 1893) contains:—

Were Protoplasmic Reversions checked by Alcohol? By Wm. H. Pearse, M.D. Edin., &c.; Early diagnoses of Mastoid Disease. By D. Milton Greene, M.D. (With an Illustration.)—Diseases of the Frontal Sinus. By D. N. Rankin, A.M., M.D., &c.; Case of Ununited Fracture of the Femur. By W. Treacy, M.D.; Medical Literature.—I. A Book of the Month. Reviewed by J. E. Bullock, M.D. Brux, M.R.C.S. Eng., &c.; News and Notes.—American Opinion.—Therapeutic Notes.—Portrait: Dr. William M. Polk.

No. 38 (March, 1893) contains:—

Constipation. By J. D. Staple, M.R.C.S. Eng. (Original Article.)—How Amputation of the Breast for Carcinoma should be Performed. By Prof. R. F. Weir, M.D. (With Two Illustrations.)—Spontaneous Cure of Multiple Papillomata of the Larynx after Tracheotomy; with the rare Anomaly of Papilloma of the Epiglottis. (With Four Illustrations.)—Medical Literature.—II. A Book of the Month. Reviewed by E. A. Piggott, L.R.C.P. and S. Edin., &c.—Books.—News and Notes.—American Opinion.—Digitalis in Pneumonia; Barium Chloride in Epilepsy: How to Cure Eczema.—A New Disinfectant Soap.—Therapeutic Notes.—Views: The Bristol Medical School: Exterior, Entrance Hall, and Lecture Theatre.

No. 39 (April, 1893) contains:—

Cylindroids, or so-called Mucous Casts. By M. Manges, A.M., M.D. (With Six Illustrations.)—A Gynecological Study. (Original Article.) By E. A. Piggott, L.R.C.P. and S. Edin., &c.—Some Physiological Experiments with Magnets. By F. Peterson, M.D., and A. E. Kennelly, Electrician. (With Four Illustrations.)—Relationship of Rheumatic Fever, Heart Disease, and Chorea. (Original Article.) By W. Downing, L.R.C.P. London, M.R.C.S. Eng.—Books.—American Opinion.—News and Notes.—Medical Literature.—III. A Book of the Month. Reviewed by J. D. Staple, M.R.C.S., &c.—Therapeutic Notes.—Correspondence.—Illustrations: The Königl. Charité, Berlin. Four views.

No. 40 (May, 1893) contains:—

Dyspepsia Among the Textile Trades Operatives, its Causation and Treatment. By J. A. Diggle, L.S.A. Lond. (Original Article.) On the Importance of Examination and Flushing of the Genital Tract Directly after Labour. By Alexander Duke, F.R.C.P.I., &c. (Original Essay.) The Result of Examinations of Sewer Gas which Escaped in Tenement and Private Houses, wherein Cases of Diphtheria Occurred. (With Three Illustrations.) Cylindroids or So-called Mucous Casts, concluded. (With Three Illustrations.)—News and Notes.—Medical Literature.—IV. A Book of the Month.—Books.—Glycerine in Constipation.—American Opinion:—Internal Urethrotomy. Therapeutic Notes.—Correspondence.

No. 41 (June, 1893) contains:—

Urethral Fever. By P. Macleod Yearsley, M.R.C.S. Eng. (Original Article.) Three Cases of Syphilis. By J. A. Diggle, L.S.A. (Original Article.) Osteitis Deformans. By H. Ling Taylor, M.D. (With Five Illustrations.)—Vaginodynia. By E. F. Frost, M.D. Case of General Dyscrasia. By F. P. Emerson, M.D.—Books.—News and Notes.—Continental Practice.—American Opinion.—Therapeutic Notes.—Portrait: The late Prof. Marcus Beck.

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For Mental Overwork, Sexual Debility, Impotency, Nocturnal Emissions, the result of excess; Mental Apathy or Indifference, and an Enfeebled Condition of the Genital System, with Weakness or Dull Pain in the Lumbosacral Region. As recommended by Dr. GORDON JONES, of the Soho Hospital for Urinary Diseases. In bottles of 100. Price 4/6. To the Medical Profession, 3/9; post free, 4/- No samples.

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Succus Alterans (McDade)

Is a vegetable alterative of unique value in the treatment of SYPHILIS, secondary and tertiary, Eczema rubrum, Psoriasis, Scrofula, Rheumatism, and other diseases of a Syphilitic origin.

Each pint bottle of "SUCCUS ALTERANS" (McDADE) contains in natural combination the unimpaired virtues of sixteen troy ounces of the true medicinal plants, *stillingia sylvatica*, *smilax sarsaparilla*, *phytolacca decandra*, *lappa minor*, and *xanthoxylum carolinianum*, manufactured while still in the green state, in the same proportions as indicated in the original formula published by DR. J. MARION SIMS, in the *British Medical Journal*, March 10, 1883, and endorsed by DR. B. RUSH-JONES, and many other eminent physicians. It is certified by DR. McDADE as a strictly trustworthy and uniform preparation, made only from green drugs collected in proper season, and is the only preparation from which the remarkable results obtained by DR. MARION SIMS and others can be relied upon. What these results are may be briefly indicated by extracts from the letters of English medical men who have employed this remedy:—

I have prescribed your Succus Alterans in syphilis accompanied with obstinate skin affections with much good effect. It seems to raise the vital power so well in the depressing stage of the disease.
JAMES STARTIN, M.R.C.S.ENG., Senior Surgeon to the London Skin Hospital; Consulting Surgeon to the Sheffield Public Skin Hospital.

With regard to the preparation Succus Alterans, the patient was suffering from syphilis of throat, mouth, and tongue, and had been under treatment at several Metropolitan hospitals, presumably with the usual anti-syphilitic remedies. This was a case of the later class of syphilitic manifestations, viz., those of a gummatous character. The lesions were severe and deep, and there were signs of the same disorder affecting the cerebrum. I must confess to be one of those who regard mercury alone as being of any real use in syphilis, and therefore I must say that I was somewhat surprised at the rapid improvement this patient made under 1-drachm doses of the remedy. The fissure in the tongue began to close, and a nasty deep ulcer of the lower lip is almost well.

JOHN G. MARSHALL, B.A.CANTAB., M.B., M.R.C.S.ENG.

I have used in my practice the preparation known as "Succus Alterans" (McDade), and have much pleasure in bearing testimony to its great value.

For diseases having their origin in a syphilitic source, I believe the "Succus" to be the one reliable specific, for I may add that invariable success has been met with by me when prescribing the remedy in question, even after the failure of all other alteratives.
WM. ED. GOODFELLOW, M.R.C.S., L.S.A.

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In one case of specific disease of many years' standing, my patient had been obliged to take Pot. Iod. in large, depressing doses ever since the onset of the attack, and it really seemed that he would be doomed to a life of Iodide of Potassium. I gave him "Succus Alterans McDade," and in three months he was a different man; in six months he was practically cured, and he has been enabled to do without the Iodide ever since the commencement of the new treatment. As an alterative tonic its effect is simply splendid.

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Pil. Aphrodisiaca (Lilly) are likewise recommended to the attention of the Medical Profession by DR. GORDON JONES, of the Soho Hospital for Urinary Diseases.

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This Soap is prepared in accordance with the suggestions of Prof. Bergmann, M.D., of Berlin, and is highly recommended by physicians, including those in the army, for the treatment of Scabies, *Pediculi capitis et pubis*, &c.

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Parasiticide, and useful in the treatment of pimples, etc.

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(10 per cent. Pix liuida.)	

For herpes, pimples, dandruff, etc.

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For cutaneous eruptions, herpes, chilblains, redness of the skin, dandruff, freckles, prickly heat, grubs, pimples, etc.

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Recent and exhaustive experiments with Boracic Acid have proved its very great utility in securing a healthy condition of the epidermis, especially in efflorescence, rash, red spots, scales, dandruff, salt-rheum, and serpiginous excrescences, and the use of this Soap cannot, owing to its excellent effects, be too highly commended.

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For exanthematic diseases.

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Prepared by the suggestion of Prof. Fuerbringer, M.D., of Jena, and Prof. M. Kaposi, M.D., of Vienna. Used in chronic skin diseases of all kinds, dry and moist herpes, grubs, pimples, desquamation of the scalp, &c.

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Mild in character and disinfectant.

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Antiseptic; employed to correct the fœtor of suppurating and gangrenous wounds and ulcers, and found useful in many skin diseases of long duration, such as herpes, itching of the skin, grubs, and pimples. It is used with excellent results as an antiseptic and disinfectant, like Carbolic Acid Soap, but is distinguished from that by its milder and more agreeable effect.

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(5 per cent. Sod. Sulfo-ichthyol.)	

The substance used in this Soap is obtained from a bituminous mineral recently discovered in the Tyrol, and has already been extensively used by Prof. Unna and others in the treatment of skin diseases. Its value is principally due to the large proportion of Sulphur and Oxygen it contains. Ichthyol Soap is especially useful in the treatment of eczema, erysipelas, salt-rheum, ring-worm, comedones, red spots, and in all stages of rosacea, and will produce a fresh and healthy complexion. Redness of the skin is most favourably influenced by the use of this Soap. In light cases patients should wash the affected parts frequently with the Ichthyol Soap, especially after dinner, and before going to bed, with as warm water as can be comfortably used. The best effect is obtained if the lather is allowed to remain on the affected parts during the night.

Mr. Richards, Agent for J. D. Stiefel, Offenbach, regrets his inability to offer Samples of Stiefel's Soaps.

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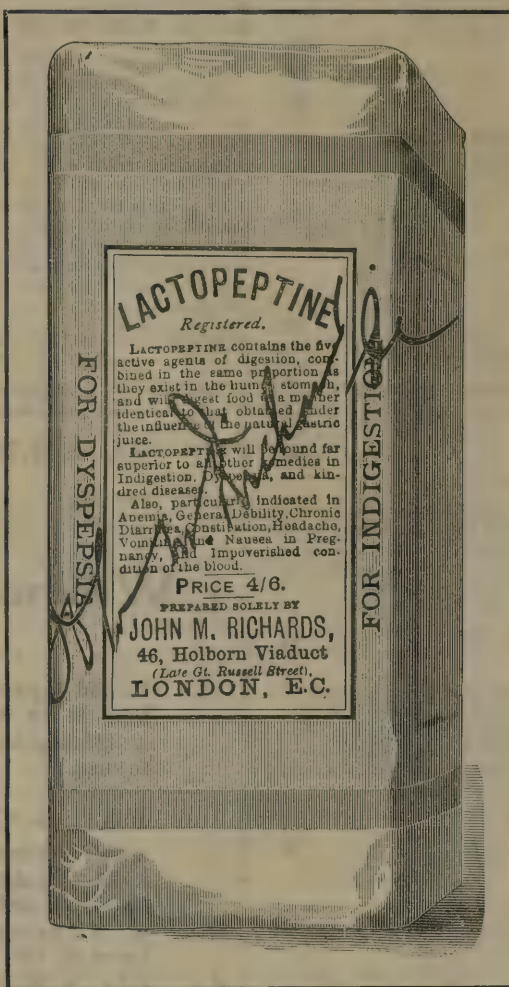
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It may be had by Medical men in 1-lb. and ½-lb. bottles at 12s. 6d. per pound, net, with YELLOW label.

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THE SURGERY OF GALL-STONE OBSTRUCTION.

By ROBERT ABBE, M.D., Surgeon to St. Luke's Hospital, New York; Professor of Surgery at the Post-Graduate Medical School, &c.

[Read before the Academy of Medicine, March 16th, 1893.]

It may well be conceded that the management of gall-stone obstruction of the biliary ducts, in the vast majority of cases, is one that interests the practitioner of medicine, and is best left in the hands of the physician rather than the surgeon. It is probable that not one per cent. of patients suffering from gall-stone colic come to a condition that jeopardises life. The malady is often grave, and tedious. It is complicated by various surgical accidents, ulceration, perforation, septic infection, exhausting fever, profound cholemia, any and all of which may be ultimately recovered from if we choose to wait. The physician of conservative practice, who intelligently watches the wonder-working of Nature, stores in his memory scores of cases of gall-stone colic, where, even after repeated and profound illnesses, the patients have convalesced to perfect and enduring health. We must all acknowledge, however, that when the grave forms of obstruction ensue, our responsibilities in delay increase with each day's demonstration that surgery is prepared to cope with the evil we are watching.

The picture of the parts in trouble that presents itself to the mind of the observer at the onset of an attack is not a uniform one. Diagnosis is by no means simple, less so for the mild cases than for those more pronounced. One sees many forms of gastralgia, dyspepsia, pleurodynia, colic from colon distention, and other recurrent discomforts that closely resemble the gall-stone colic when very small stones are passed. The diagnosis rests with an associated group of symptoms, rather than physical signs, to wit: pain and constricted feeling behind the right hypochondrium, rather than in the abdomen, nausea, tenderness to pressure, absence of fever and of intestinal distention. There is very rarely jaundice, and the illness is over in a few hours.

The picture of such cases comprises the obstruction of the ducts by stones only a little larger than the ducts, and which are easily moved on by peristalsis. When we remember that statistics show that one in ten of those who reach middle life are known to have gall stone, we are the more ready to believe that the larger proportion of cases of brief spasmodic attacks of pain in the anterior hepatic region are due to light gall-stone attacks. Yet we may be deceived by the absence of jaundice and a lull in the acute symptoms into thinking the stone had passed, whereas it has only become permanently lodged in the cystic duct. In this condition a group of cases will be found showing a picture of pretty uniform type. The cystic duct becomes blocked permanently about as often as the common duct. If a stone no larger than a haricot bean excites inflammation enough in the duct to produce ulceration a cicatricial stenosis ensues which prevents the stone moving either way. Other stones remaining in the gall bladder beget cholecystitis and a copious inflammatory exudation ensues, with tumour and pain.

The fluid is found, after a while, entirely free from bile, either milky or colourless. It may form a large recognisable tumour, which in time may be absorbed, leaving only an atrophied remnant of gall-bladder encysting the incarcerated stones painlessly. But this is not usually the case. Repeated efforts are made to throw out the foreign bodies and correspondingly persistent pain without jaundice brings the patient to the surgeon. This picture is one of the most common and has yielded many of the most satisfactory results of the recorded operations. I can best illustrate it by a case from my own books.

A woman of thirty years came under my care with a history of many attacks during ten years, the intervals ranging from two weeks to three months. The severity of the attack had induced morphine habit. Jaundice had sometimes super-

vened, but not during recent years. She had become emaciated and discouraged. The gall-bladder region was tender on palpation, but no tumour could be felt; even her corset pressure was painful.

On operation I found the gall-bladder adherent to the stomach by old adhesions. It was not larger than normal, but on section contained a thin, whitish, mucous fluid, and fifty-three small stones. The presence of fluid devoid of colour and chemically of bile also in the gall-bladder is always conclusive proof, as in this case, of the obstruction being confined to the cystic duct. My inability to pass a probe through the duct or to feel a stone in it on palpation was no proof that there was not a small stone there. The patient made a quick recovery with a permanent mucous fistula, from which bile never came. Six months afterwards I reopened the abdomen, dissected away the entire gall-bladder, tied a ligature about its duct, and found there a small stone incarcerated between two tight strictures, as if it had been lodged there for years.

The patient made an uninterrupted recovery, abandoned the morphine habit, and for four years has maintained robust health, without the least recurrence of pain.

In another case, reported elsewhere, a young married woman came under my care in a condition of grave hectic and debility, with a tumour on the right side below the ribs. This had existed for six months, with vague colicky pain at first, but never a frank paroxysm. She had never been jaundiced. The mass was tender, hard, and movable. It had been diagnosed a cancer.

I opened the abdomen and found a dense, malignant-looking mass as large as one's fist, and universally adherent. On cutting into it I felt that it was even more certainly, from clinical appearance, a cancer. In its centre was a small amount of muco-pus, scarcely two drachms. No stone could be felt within it, nor on examining the ducts from the mesenteric side. She made an easy convalescence. The hectic disappeared. In six months a sinus remained through which I removed from the remnant of the gall-bladder a solitary gall-stone, the size of a pecan-nut, which had worked back from the cystic duct towards the easiest outlet. A few months later the entire hyperplastic tumour which so resembled a hard cancer had disappeared.

Catheterism or probing of the cystic duct when it has not been dilated by the passage of stones into the common duct is a matter of impossibility in the majority of cases, hence the return flow of bile through the gall-bladder fistula left after operation is often the only proof we can have of the perviousness of the cystic duct. I speak only of the class of cases where obstruction is in this duct alone, as illustrated above. These constitute a considerable part of those demanding surgical relief.

It is not to be wondered at when we consider the extraordinarily tortuous and convoluted anatomy of the canal. Few who have not made a minute dissection of it can realise that there are scores of overlapping valves in the two inches of its course. Terrier and Dally in their admirable study of the question of possible catheterisation of this canal have been unable to report success in more than one case in four.

I show an illustration of a normal duct which I hardened in alcohol after distending with alcohol, thus maintaining the most normal relations of the parts as found in life (Fig. 1).

It seems incomprehensible that a stone should ever escape from the gall-bladder, and one does not cease marvelling when he has found large and small stones in every stage of progress through this minute duct. The distensibility of the canal far exceeds that of the parturient passages. Rokitsky says that a stone even as large as a hen's egg has been known to traverse the entire canal—and be safely delivered into the bowel.

One might think that the gravest cases of gall-stone disease must fall to the class of cases where obstruction has occurred in the common duct and the flow of bile is entirely dammed back into the liver. This is by no means so! The acuteness of the inflammatory onset may menace life at the first attack

when the stones have not left the gall-bladder. I have little doubt that the life of the patient, whose case I will now narrate, was saved by prompt operation.

Late in the evening of April 26, 1892, I was called to see a lady of about forty by Dr. J. C. Warren. She had never had trouble until two days before, when severe colic, vomiting, and



FIG. 4.—Section of Normal Cystic Duct Showing Valves.

purging came on suddenly. For two days the gravity of the symptoms increased, and before I saw her had become extremely violent—resisting the quieting action of morphine, freely given by Dr. Warren. When I saw her she was having intense paroxysms of pain, lying with knees drawn up, and moving only when forced to vomit. Her condition seemed desperate, her eyes were dark and sunken, pulse poor, and she was evidently approaching collapse. It was impossible to palpate the abdomen, but a full dull area was discerned, extending vertically from the liver towards the groin, and ending considerably below the navel.

I operated at midnight. The gall-bladder was greatly distended and enlarged downward, resting on the kidney. It was coated with a layer of new lymph, from peritonitis that had

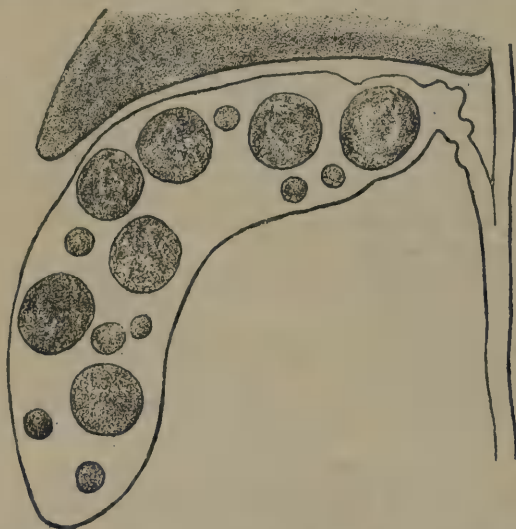


FIG. 2.—Gall-stone Obstruction of Cystic Duct with Acute Distention.

already set in, yet her temperature before operation was 100½ degrees F. Slipping my fingers into the abdomen I could feel only one stone at the back of the sac. Protecting the abdomen by thin flat sponges within it, and drawing out the end of the tumour, I incised it, and evacuated a tumbler full of mucopurulent fluid, not bile, though stained with it, and seventeen gall-stones (Fig. 2), eight of them large and remarkably uniform, nine small and also uniform, all spherical, the larger ones three-quarters of an inch in diameter, the smaller ones one-quarter. One of the largest ones was tightly wedged in the beginning of the cystic duct.

After evacuating the stones, I closed the cut end of the bladder about a syringe and distended the cyst with Thiersch's solution to see whether it could be emptied into the intestine by pressure, and thus prove the patency of the duct. It was impossible to force water through. I therefore sutured the

cut end in the wound and established a fistula. The patient's temperature fell to normal on the following day. Bile flowed freely from the fistula, which closed spontaneously in three weeks. The patient has remained in perfect health since then, now nearly a year.

The question of the endurance of the patient to the physical strain of repeated attacks is one that may legitimately influence the surgeon in advising operation. A striking case in point may be cited here.

A lady, sixty-four years of age, had, during four months, been under Dr. Partridge's care for severe gall-stone attacks, repeated from four to seven days apart, each accompanied by clay stools, porter-like urine, and jaundice. Each time she was encouraged to hope that the last stone had passed. She was unable to leave her bed. The pain became practically continuous, but the jaundice cleared up. The gall-bladder distended and could constantly be felt. It was evident a larger stone had finally blocked the cystic duct. On opening the abdomen, the distended viscus could readily be lifted out of the wound. Three good-sized stones were found as shown in Fig. 3. No suppuration nor peritonitis had been set up. Two of the stones were tightly wedged in the cystic duct, and were with care worked back into the gall-bladder. The cystic duct was then found permeable to a small bougie which passed into the duodenum. I therefore sewed up the wound in the gall-bladder, and, after cleansing, dropped it back into the abdomen.

Recovery was uneventful, and she has enjoyed unprecedented health for the two years that have passed.

The grave condition of obstruction of the common duct presents another picture, and one in which the new lines of surgical work have more to do. There is no point of the common duct (though it seemed to be until very recently) from which impacted stones have not been removed. It may reasonably be said that, without operation, these cases are almost hopeless.

One must recall that anatomically the common duct is buried in the meshes of the lesser omentum, and descends behind the duodenum, to which, and to the pancreas head, it is intimately adherent. Close to it are large veins, and beside it the portal itself. Unless distended by a stone, it is practically impossible to feel it. When it is distended the duct of the gall-bladder is also apt to be. Such cases are illustrated by Figs. 4 to 6.

Intense cholemia and its train of constant attendant symptoms makes the diagnosis of obstruction unquestioned. The diagnosis is not always easy, however, between cancerous and gall-stone obstructions.

The main fact, in the absence of tumour, must be the history of paroxysmal pain antedating the usual year or two that would develop a matured cancer. Chronic jaundice, without preceding gall-stone colic, is most often due to malignancy.

It has been advised by surgical authorities, until very recently, that profound jaundice is in itself a serious drawback to operative work. Accumulated experience now shows that with modern, thorough methods, the cholemia is not a drawback to operation.

In the following two cases the most profound jaundice had been constantly present for over two years. In one the blood even had a noticeably slippery feeling from retained bile, yet both made perfect recoveries.

On April 13, 1889, I operated on a lady aged thirty-six, who had gone deeper and deeper in sickness after her first attack of gall-stone colic, two and a half years before. She became almost a black-green, lost thirty pounds, had progressive indigestion and vomiting. She had stools entirely devoid of colour, and urine like porter. Her paroxysmal pains were "terrible," and petit mal had been recurrent daily for two months. The urine had five per cent. of albumen and some hyaline casts. Palpation failed to discover a gall-bladder. On doing laparotomy, I found the gall-bladder buried in adhesions to the stomach, omentum, and colon, but not distended. Several gall-stones were removed from the incised viscus, and a large one found more than half way down the common duct, absolutely immovable (Fig. 4). I cut the common duct open and took out the stone, then removed the damaged gall-bladder, and putting a large drainage-tube into the hepatic duct, sewed up the common duct with fine silk (Fig. 5). Around the drain that emptied the hepatic duct I put a larger one, reaching to the common junction, and packed in a light iodoform tampon, against which intestines would rest, and in a few hours form a solid wall of lymph, precluding extravasation into the peritoneum. The patient lost all her bile through the tube for five days. The inner tube was removed on the second day, and the sinus closed in three weeks.

The patient maintains perfect health to date, having in four years had the felicity of bearing a much-hoped-for boy.

The second typical case of this group I operated upon the months since. The patient was a married woman, referred to me by Dr. Morrison, who had been treating her more than two years for almost weekly attacks of cutting pains and biliary colic. Hypodermics of morphine had always been needed to allay suffering; jaundice and vomiting had become chronic, and the patient a wretched sufferer. There was no tumour of the gall-bladder to be felt.

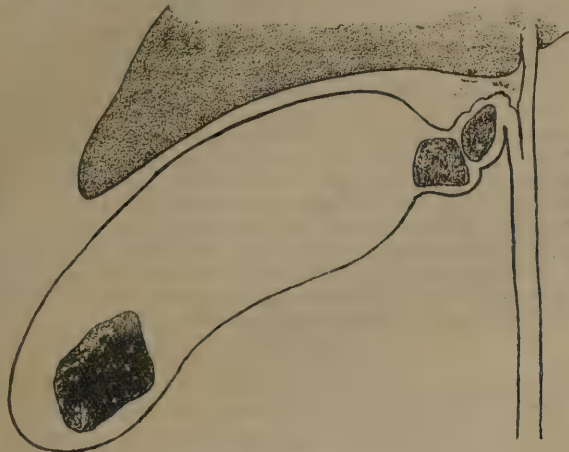


FIG. 3.—Gall-stones Obstructing the Cystic Duct.

I operated January 3, 1893 (see Fig. 6). The gall-bladder was tightly adherent to every neighbouring organ. When it had been incised, dark, tarry bile flowed freely, and I removed one large and twenty small calculi. The dilatation of the duct was wide enough to allow my index finger to ascend into the liver and down the common duct. In the latter a very large stone was found, an inch and a half below the junction, so tightly held between the two strictures that it was necessary to introduce a knife and cut the strictures from within, after which I succeeded in liberating the larger stone. The patient made a speedy recovery.

Thus I have given six cases of the gravest phases of gall-stone obstruction, all of which have made perfect recoveries. All were women.

The literature of the cases of free incision of the distended ductus communis choledochus now includes a considerable number where suture of the divided duct has resulted in immediate healing. The recoveries are so uniform that it can be regarded as scarcely more dangerous than opening and draining the gall-bladder. That it is a more difficult operation to suture a small duct in a deep wound goes without saying, but



FIG. 4.—Gall-stones Impacted in Common Duct Two and a half Years. Removed by Incision of the duct with removal of Gall-bladder.

the operator will find that under the pathological dilatation the walls are thickened, and when the stone is out they are free enough to be easily secured and tightened by stitches. The continuous silk suture is the best.

For the comfort of any who may be forced to leave an incised common duct unsutured it may be quoted that during the past year Bland Sutton removed three stones from the

common duct by incision, and left it open, with a tube running down to it. The peritoneum was shut off by adhesions, easily generated around a small gauze tamponade. The bile discharged freely, the wound granulated and healed up in three weeks.

Keen also bored through the head of the pancreas to get at a hard knot of stones in the lower end of the common duct, and leaving it open, drained by the tube. The wound healed kindly without suture.

The lower part of the common duct may occasionally hold the obstructing stone. This is not accessible to the knife applied from the outside of the duct, for the anatomical reason that it is hidden behind the duodenum. There is but one safe and elegant approach, if I may so speak, to it. Such an opportunity was afforded by an obstructing stone in the outlet in a case reported by Dr. McBurney last year, in which he incised the duodenum, released the stone, sutured the duodenal cut, and saved the patient.

This method of searching the duodenal end of the duct I afterwards attempted in a case of what proved to be malignant obstruction. As there was no stone in the duct to mark its position, it was impossible for me to identify it. It satisfied me, nevertheless, that the intestinal wound, which healed most perfectly, is an innocent addition to the surgical interference, if it be properly sutured.

Cholelithotripsy, or crushing the stone in its duct, either by digital pressure only, or by dressing forceps shielded with rubber tubing, has had a dozen demonstrations of its utility in soft stones, since first used by Tait. Robson and Courvoisier have advocated and practised it, with only one recorded death, and that one not proven as due to the bruised duct. Marriot reported a recovery after crushing a large hard stone through the cystic duct walls, by rubber-padded forceps, after he had

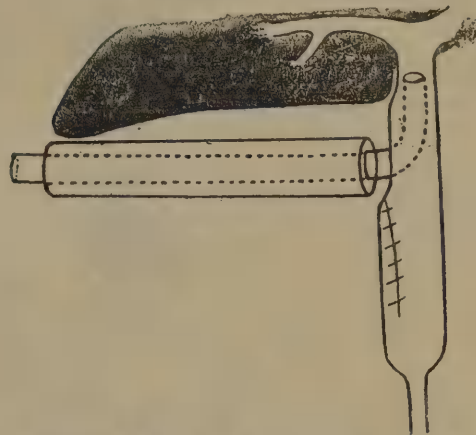


FIG. 5.—Showing Method of Suture and Drainage after Fig. 4.

vainly tried to break it up by needles. The fragments of stone have in all cases passed off spontaneously, with a slight colic, in a few hours.

The method should never be lost sight of, as it is more often available than cutting, and it may yet hold a high rank. Its present record justifies its being used where one or two moderate-sized stones are found, especially in inaccessible places. Free incision is now recognised as so safe and successful a method that any substitute for it, except for emergency, does not represent the best surgery.

One new method has entered the field to dispute for preference with the two just mentioned. That is, the formation of an anastomosis between the gall-bladder and the bowel, that the discharge may be directly into the bowel when the duct is obstructed irretrievably.

To unite the gall-bladder to the bowel by the suturing method of lateral anastomosis is a quickly accomplished and admirable procedure. The use of vegetable or bone plates of Senn has few advocates for use in the gall-bladder. Chevasse used the plates of bone to unite the gall-bladder and the small intestine, but got a combined biliary and fecal fistula, which, nevertheless, soon healed and allowed the bile to flow into the bowel.

The preferred method of suture has been by a double row of Lembert stitches around the free incisions in the opposing viscera. It takes but fifteen minutes to do it well.

Murphy, of Chicago, has lately advocated, and used successfully in three cases, a simple device, the simplest that has yet been offered for speedily making anastomosis. (See *New York Medical Record*, December 10, 1892, p. 665.) He uses two metallic buttons, shaped like mushrooms, with hollow stems,

fitting one into the other; one button is inserted through a slit made into each of the opposing viscera and saturated there; the stems remaining outside are pressed together and lock between the edges of the buttons the involved bowel and gall-bladder walls. The tight pressure causes sloughing of the included circle in a few days, and sets up adhesive union of the two edges.

Murphy used this device three times in the human subject with perfect success. The buttons were voided in due time and the bile flowed into the bowel. Each of the cases seems to have been one where the stones might have been removed and the natural channels cleared up, without attempting to establish an anastomotic opening where the calculi could escape into the bowel, as they did after the buttons had sloughed out.

Ingenious and successful as this method is, of quickly establishing a new channel for the bile into the intestine, it seems to me a retrograde step in surgical work to sacrifice the perfection of work for the sake of a brief and usually unnecessary saving of time.

Dr. Murphy operated in one case in eleven, and in another in twenty-one minutes, but paid no regard to how obstructing stones in the common duct were going to be helped to escape.

The operation of anastomosis between the gall-bladder and intestine was first done by Von Winiwarter in 1880; again by others in 1887-89, and since, in about twenty recorded cases, and has grown in favour as regards safety and utility.

It is a surgical imitation of one of Nature's methods of getting rid of stones by ulceration into the nearest viscus. It

that bile is excrementitious, and that we can with advantage let it flow into the alimentary canal low down. The anastomosis is very easily made, and does not involve dragging the small intestine across the colon.

The subject of gall-bladder surgery was a small one when Marion Sims wrote of it first in 1878, only one case having been recorded prior to that, but now it has crept into the field of abdominal surgery with a brilliant record. Robson reports forty operations with two deaths. Tate, Thornton, Courvoisier, Terrier, Czerny, and a score of other names have added their testimony to the safety of the operation and brilliancy of the results. The mortality is not more than five or six per cent. Cases of every shade of interest are being reported, until it seems now that there is almost no complication one may encounter that cannot be met by simple operative principles.

The most grave and irremediable condition is of course cancerous obstruction, and it is here that I believe the field of anastomosis of the gall bladder and colon will find its great usefulness. Except in that, and in cases of absolute cicatricial stenosis of the common duct, it may be better supplanted by the judicious use of the knife, or of crushing, by which gall-stone obstruction has been so well demonstrated to be safe, no matter what part of the duct is choked.

DAMIANA; A NERVE TONIC AND STIMULANT. WITH ILLUSTRATIVE CASES.

By J. A. DIGGLE, L.S.A. Lond.

[An Original Article specially written for MEDICAL REPRINTS.]

DAMIANA is the name commonly given to the leaves—and preparations thereof—of two varieties of a small mintlike plant belonging to the *Nat. Ord. Turneraceae*, viz.: *Turnera Microphylla* and *Turn. Aphrodisiaca*. Its natural habitat is Western Mexico, and among the ignorant women of that part it has a great reputation as an emmenagogue. This is scarcely borne out by trials among practical physicians, and its true action seems to be that of a nerve stimulant and sexual tonic. It is also a general tonic, and is cathartic in its action, producing large soft evacuations.

If we look over the list of therapeutic agents we have in this country, the want of a really dependable sexual tonic and aphrodisiac is at once apparent. In most cases we have to depend on general tonics, such as quinine and strychnine, &c., and over and above these phosphorus, which seems the only direct sexual tonic we have. It is with the hope of inducing others to give damiana a trial in such cases of sexual debility that this article is written. It has been extensively tried in America, and with uniform good results. In its native home, Mexico, it is used generally in the form of an infusion sweetened, and, except for the rather strong flavour, is not unpalatable in this form. By the American and English druggists it is put up in the form of elixir, fluid extract, and dry extract, for making into pills. It is generally found combined in the latter with phosphorus, ext. nucis vomica, or quinine.

Damiana has a powerful action over the urinary organs as well as the sexual appetite, and generally increases the flow of urine. Although slower in action than buchu or uva ursi it is said to act equally as well, if pushed persistently, in all inflammatory diseases of the bladder and genito-urinary passages. In impotence and spermatorrhœa it acts most beneficially. It is considered by many to act, like strychnine, as a true nerve tonic, especially on the brain and great nerve centres. In happy contrast to strychnine it is almost non-poisonous, and can thus be used more freely. Probably it acts as an invigorator of the primordial nerve cell, exciting cell nutrition by enabling the nerve cell to eliminate its proper nourishment from the blood. On the medulla oblongata and spinal medulla it has a great effect, and the motor tracts seem more susceptible to it than the sensory.

This seems to show that it might be tried with advantage in motor paralysis, and I believe it has been so tried, but with what success I do not know. In one of my cases the paralysis had disappeared before I began its exhibition, though the impotency continued, and it was for the latter I began the damiana.

If the impotency is caused by want of erectile power in the penis, it is especially valuable and reliable. In this connection, taking the line that damiana is a true nerve-centre tonic and stimulant, it can scarcely be called an aphrodisiac. In those cases in which the patient falls into a pitiable state of nervous weakness and almost imbecility, from excessive venery or onanism, it is said in full doses (Ext. 5-15 grs.) to cure in a very short time. In the second of my cases, of which notes are appended,



FIG. 6.—Large Gall-stone Two and a half Years in the Common Duct.

has the endorsement of everyone who has tried it—Courvoisier Terrier, Robson, and others—and seems to be unattended by risk when properly done. The fear that infectious inflammation from intestinal contamination would follow is groundless. The few autopsies that have followed at not very remote dates after operations have shown that a natural-lipped valve forms at the crifice and protects the gall-bladder from regurgitation from the bowel. The greater danger appears to be that cicatricial stenosis of the opening will close it. It is a natural law that inevitably works against the surgeon in this effort. Autopsies show hundreds of scars of adherent gall-bladder and bowel, but very rarely one that has kept open after the stone has ulcerated its way out. What more can we hope for the artificial opening? The only ground is, as far as I can see, in an incision of an inch and a half, which will give permanence.

Richelot, of Paris, operated by a small opening in a case of obliterated common duct, and some months later, the jaundice having recurred, autopsy showed an obliteration of the opening. On the other hand, one case (Mayo Robson's) has survived nearly three years without stenosis. In his case he joined the gall-bladder and the colon at the hepatic flexure. In two other (Courvoisier's and Chevassé's) most successful cases the colon was used.

It seems to me probable that the colon may be always used with great advantage. The bile has been considered a necessary digestive secretion until of late. It has been shown that patients with chronic fistula pouring out the entire bile-flow often gain in weight and health. This would encourage the view

caused by excessive venery, I had got the general health pretty well re-established before I began the damiana, but when I did commence the sexual improvement was much more rapid.

In impotence after excessive venery, and after hemiplegia, are the only two classes of case in which I can really speak from experience, but the American profession give it also in many other diseases, such as dysmenorrhœa and other uterine maladies.

"So far from it being an aphrodisiac or excitant of erotic desire," Dr. Polk says (*Va. Medical Monthly*, March, 1879) "this idea is without basis, and in several cases of abnormal sexual appetite it acted as a direct calmative to the over-excited sexual organs."

In relation to its action in combination with phosphorus, it is supposed to act on the nerve-cell nutrition as a digestive acts in the stomach, making the nerve food present more easily assimilable, in this way building up the exhausted nerve-cells, and making them fit for their work. Dr. Polk also says: "Damiana has an immediate and direct action on the nerve centres which preside over respiration and nutrition. It imparts to them permanent tone and vigour." Damiana can then be used in impotence, in spermatorrhœa, in atrophy of the testicles, and also incontinence of urine; also as a powerful stimulant of the cerebral faculties, and as a general tonic in all cases of disease of the pelvic organs. Acting also on the sympathetic, it is said, when taken in large doses, to produce a peculiar intoxication, with slight pain about the prostatic region.

In very large doses, symptoms of poisoning, somewhat resembling those of strychnine, are produced, tetanic convulsions, opisthotonos, and in co-ordination of muscular power.

Finally, the elimination of phosphorus in the urine so often seen in nervous diseases is said to be much checked by the administration of damiana, and it thus probably prevents waste of essential nervous pabulum. Having thus roughly sketched the general therapeutics of this remedy, I will now proceed to give notes of two cases in which I have used it with benefit.

CASE I. A—H—, a gentleman about thirty-two years of age, married, with one child, sent for me one night in winter about 12.30 a.m. He had been to a masonic dinner, and afterwards had indulged more freely than his wont in stimulants, whisky principally. It was a bitter cold night, the ground covered with snow. A friend who had brought him home in a cab stated that Mr. H— had just descended the steps from the hall, whilst he himself stood at the top, when, to his surprise, H— spun round several times quickly, and then fell heavily to the ground, his head catching the bottom step of the flight, which had been swept clean of snow.

Running down at once, he raised Mr. H—'s head, and found him breathing heavily and quite unconscious. Getting a cab, he had him lifted in and driven him home as soon as possible.

When I saw H—, he was lying in bed and still only partly conscious. I found a wound two inches long in the scalp, over the right parietal bone, but no depressed bone; the wound had bled freely. Whilst stitching up this, the patient recovered partially, but spoke very indistinctly and complained of his head feeling stupid. I attributed this partly to the alcohol he had swallowed, and thinking he would be better in the morning, I left him. Visiting him next morning I found he had rested fairly well. The wound was still rather painful. His wife said on trying to get up this morning out of bed he had found that he could hardly grasp with his left hand, and that his left leg was also slightly paralysed. I again examined the head carefully, but found no further signs of mischief, and so came to the conclusion that the hemiplegia was caused by the shock.

I told them so, and gave a favourable prognosis, which was confirmed by events, as in about a month he was as well as ever—with one exception: he had lost his sexual appetite and power of penile erection.

For this I ordered cold sponging to the spine, generous diet, complete rest from all attempts at coitus, and an iron, quinine, and strychnine mixture.

A week passed with little benefit; the general health improved, but he felt no inclination at all towards his wife. I encouraged him to persevere, and in addition to the mixture I gave him some pills as follows: *R* Phosphori, gr. $\frac{1}{60}$, Quin. Sulph. gr. i., Ext. Nucis Vom. gr. $\frac{1}{2}$, in pil. i., i.t.d.s., and told him to see me again in a week. I also lent him a galvanic battery with instructions how to apply the current,

In the meantime, one afternoon I happened to call on a friend, a medical man, and accompanying him into his surgery I saw some pills on the shelf, a bottle of Pil. Aphrodisiaca (Lilly's)¹ containing ext. damiana with ext. nucis vom. and phosphorus. Remembering to have seen some notice in a journal of this remedy for impotence I asked him if he had tried them. He said "No," but on mentioning I had such a case he kindly allowed me to take them to try what effect they would have.

When Mr. H— next appeared I gave him a box and ordered one pill twice daily.

After a week I ordered two of the "Lilly" pills for a dose, still keeping up the electric applications. In about three weeks he was decidedly better, and after taking the one bottle I got first (100) and about one-third of a fresh one I procured, he confessed to being as well as ever he was in his life, and perfectly competent for his marital duties.

The remainder of the pills lay on my shelf for over twelve months, until the next case brought them to my mind.

J. T—, aged twenty-six, a coachman to a neighbouring gentleman, came to me suffering from spermatorrhœa, and in a pitiable state of nervous exhaustion and weakness and mental worry. He had lived before in Birmingham, and had indulged in excessive venery, and I shrewdly suspected onanism also. He said the mere friction of his dress was enough at any time to cause a sexual emission, and never a night passed but he soiled his night clothes in the same manner. He said he was weary of his life, and in addition to this he had been engaged for two years to be married, but felt himself in no way fit. One testicle was slightly enlarged, and tender. I found no mischief in the urethra, though he acknowledged a slight attack of gonorrhœa twelve months previously. I gave him a mineral acid tonic with gentian, and fifteen grains of kali bromidi to take every night, and ordered him to suspend the testicles in cold water before going to bed at night. When his appetite got a little better, I gave him quinine and iron ter. die. In about a fortnight his general health was better, but the emissions still continued, though not so frequently.

I then bethought me of the damiana pills (Pil. Aphrodisiaca, Lilly), and put him on them twice a day, giving him in addition only the bromide at night. In a fortnight he improved wonderfully, the emissions had ceased for as many as two, three, and latterly four days, and he had put on a little flesh.

At the month end from beginning the damiana he was still improving, and I then dropped the bromide and ordered two pills of damiana at a time.

He still continued to improve, and at the end of six weeks had gone one week without any loss of semen.

He discontinued treatment at the end of two months, and has since got married, and is perfectly well.

EXTENSIVE WOUND OF THE ARM AND AXILLA —HEALING WITHOUT CICATRICAL CONTRACTIONS.

By A. RADCLIFFE, M.D.

IN cleaning the saws of an eighty-saw cotton gin while it was running, the man's shirt-sleeve caught in the saws, dragging him on to them. His arm encircled the saws, and the breast-board, weighing about one hundred and fifty pounds, fell upon his back and held him there until the engine was stopped. Besides some small cuts about the face, the upper lip was split in two places, the lower lip cut clear across, so that in protruding the tongue it came out through the cut. The shoulder was dislocated backward. Commencing at the middle of the first phalanx of the little finger, which was cut nearly off, the skin on the inner side holding the digit and sustaining vitality, the cuts were every three-fourths of an inch apart on the ulnar side of forearm, up to two inches below the elbow, cutting very little deeper than down to the muscles. The cut over the styloid process of the ulna was, however, deeper, as was the one immediately below the elbow. Extending upward from two inches below the elbow, the skin and fascia were cut off from the posterior half of the arm and shoulder, hanging in narrow strips, thick with cotton and dirt. All the skin of the axilla was cut away, and a place about five inches by six inches, extending down the side of the chest from the axilla, exposing the lower edge of the pectoralis major and latissimus dorsi, and the whole width of the teres major, the muscles

¹ Pil. Aphrodisiaca (Lilly). British Depôt is at 46, Holborn Viaduct, London, E.C. [Ed. M. R.]

forming the borders of the axilla. The several cuts about the abdomen and front of the chest were hardly more than scratches.

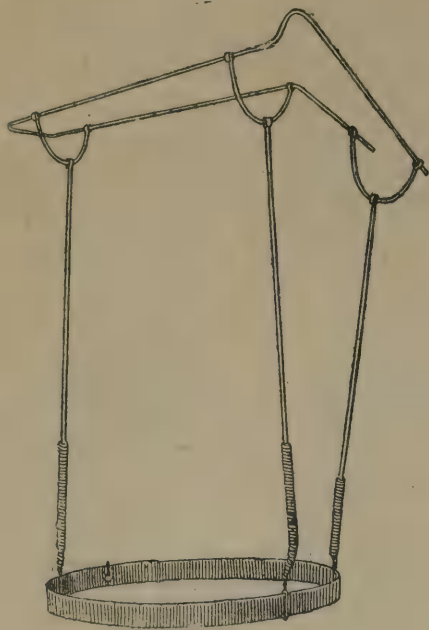


FIG. 1.

After the torn flesh had suppured and granulations started, I first made a support by fastening two shingles¹ together at their thin ends, separating the other ends as the letter V, filling the trough thus made with cotton, for the whole forearm to rest in, the apex resting in the folds



FIG. 2.

or doubling of a cloth belt, which was stiffened with a thin strap of iron, and supported by wide shoulder straps. This did admirably, but there was needed a support from

the elbow up. Another V was put to support the arm. This did nicely for a day or two, until I could make the wire support as here illustrated. The patient wore it day and night, and it is easily to be seen how he supported it comfortably by pillows. The height can be adjusted by the shoulder straps, and each support admits of separate adjustment. The cloth strips upon which the arm rested made it easy to dress the extremity. Though the axilla was all scar tissue, the man had a good arm with perfect motion, being able to raise this elbow as high as the other. So much skin and fascia of the circumference of the arm was lost, that the contraction in healing reduced its size a little. There was some skin grafts put on that assisted in healing, I giving some small ones from myself, in the hope of thereby inducing his relatives to contribute.

THE FREQUENCY OF THROAT DISEASES IN NEW YORK SCHOOL CHILDREN.

Read before the Alumni Association of the Woman's Medical College of the New York Infirmary, April 12th, 1893.

By MARIA M. VINTON, M.A., M.D.

To anyone who has the opportunity of examining the throats of large numbers of children in New York City, it is very noticeable how few normal throats are to be found, as well as how much greater the percentage of enlarged tonsils and adenoid growths in the pharynx is among children than among adults. To the throat specialist this is doubtless very familiar, but for the benefit of those general practitioners who do not meet children in large numbers, I give the result of some observations made while acting as medical examiner to the "Tribune Fresh-Air Fund" during the past two years. The children sent to country-homes for a two weeks' outing by this fund are not, as many suppose, sick children. They are received for the most part into private families, and busy housewives could not take upon themselves the care of invalids. Besides this, one of the greatest difficulties in finding homes for them is the fear of their hosts that they may bring contagious diseases with them from the crowded tenement districts of New York. That this fear is far from groundless is shown by the weekly reports of the Board of Health for the past two summers, which show from one to two hundred new cases each of measles, scarlatina, and diphtheria, to say nothing of occasional small-pox. Several children were offered last summer for inspection coming from a house which was at that time quarantined for small-pox. Accordingly each child is inspected by the medical examiner of the fund within twenty-four hours of the time when he expects to leave the city, and each throat is carefully examined for possible evidences of contagious disease. In this way I have examined the throats of about sixteen thousand children under twelve years during the past two summers. These children come from the less prosperous classes of public-school children, but not from the lowest classes of the city, and are fair examples in health of the average school children.

During my first year of this work my attention was quickly drawn to the great number of enlarged tonsils that I met with, and to the frequency of adenoid growths in the oro-pharynx. I had no opportunity of examining the naso-pharynx or the larynx, the tongue depressor being the only instrument used. Nor did I attempt any statistics, as the work had to be done so rapidly that little time was left for observation. But during last summer I made notes of 550 cases with a view to finding out the percentage of abnormal throats. These cases were not selected for their rarity, but were simply average cases, taken just in the order in which they came, but inspected with more than my usual care, as time permitted me to record them.

A fact that was most evident was the variety of colour to be observed in the mucous membrane of the throats on damp and on dry days. All the examinations were made in July and August, so that the climatic conditions were the best possible for the absence of diseases of the throat. On a dry day all the throats were of the normal pink or pale-red colour. On a rainy day, or one of those humid days with which New Yorkers are so familiar, the normal pharynx assumed a bright red, or even a purplish colour, while abnormal ones were of a dark, angry red, which would lead one to suppose that an acute inflammation existed. At the same time there was a certain amount of apparent swelling of the tissues. Yet the children were not aware of any feeling of soreness in the throat. It soon became evident to me that the congestion varied with

¹ "Shingles. Wedge-shaped pieces of wood used instead of tiles for roofing." Russell: "Current Americanisms."

the amount of moisture in the air, and that the increased colour was due entirely to that factor. A general practitioner may easily be misled by this deep colouration of the throat, found in damp weather, into the belief that an acute pharyngitis exists; I have even seen such cases subjected to treatment and pronounced cured when a change of weather relieved the congestion. On damp days there would also appear a few throats with deposits of thin white membrane on the tonsils. These were always detained in the city as a matter of precaution, and in twenty-four to forty-eight hours the deposits would be found to have disappeared, and no cases of scarlatina or diphtheria have as yet been exported to the country by "Tribune Fresh-Air Fund" children.

The commonest normal condition met with was that of adenoid vegetations in the oro-pharynx. I have called these adenoid growths purposely, although the books on throat diseases name this condition granular or chronic follicular pharyngitis. The pathological condition is precisely the same as that found in the vault of the pharynx, and there called adenoid vegetation or hypertrophy of the pharyngeal tonsil; indeed, where these growths exist in the oro-pharynx they are pretty good evidences that more of the same kind will be found higher up. I see no valid reason for a change of names in another region of the same cavity, simply separated from the naso-pharynx by an imaginary line, and by the fact that it can be easily seen when the patient opens his mouth without the use of a throat-mirror. The name chronic follicular pharyngitis is apt to produce confusion in the mind of the observer. The enlarged follicles are not mucous glands, nor is the mucous secretion increased, but, on the contrary, rather diminished. The enlargements consist of hypertrophied lymph follicles, connected by a scanty amount of connective tissue, and associated with some general thickening of the pharyngeal mucous membrane. Thus it is of the same nature as the enlargements of the faucial and pharyngeal tonsils. The result of this hypertrophy is that there are seen scattered singly over the posterior wall of the pharynx, or aggregated in flattened masses, or in ridges behind the posterior pillars of the fauces, small swellings of a darker colour than the surrounding mucous membrane. Strange to say, there are few symptoms resulting from these growths in children if confined to the oro-pharynx, as there is no increase of mucus secretion unless the pharyngeal tonsil is much affected. But the symptoms become very marked in adult life. As the child grows older a certain amount of atrophy occurs, and the condition is partly relieved, but the tissue remaining begins to produce very disagreeable results. There is constant hawking to remove mucus which does not exist, the feeling of a lump in the throat, a tickling sensation, a hacking cough, which is a source of great annoyance and concern to the patient's friends, a tendency to irritation from slight causes, and dryness and rawness of the throat. No cases of this condition were noted unless somewhat marked in character. In some the increase of tissue was only to be found behind the posterior pillars in ridges, while in others the posterior wall was more or less covered with round elevations and flat patches of hypertrophy, which were evidently only the outlying borders of much larger deposits in the vault of the pharynx, as was shown by the child's inability to breathe through the nose and the flattening of the *alæ nasi*, which contributes to the stupid expression of the mouth-breather.

Next to the adenoid growths in frequency were enlargements of the tonsils of all sizes and varieties, from the soft, "worm-eaten," spongy tonsil to the hard, fibrous ones. In many children enlarged faucial tonsils co-existed with enlarged pharyngeal tonsils, and masses on the posterior wall on the oro-pharynx, as might have been expected. On opening their mouths the tonsils were pressed inward by the stretching of the pillars of the fauces, and the whole throat seemed filled with the growths. In many there was a profuse discharge of mucus from the anterior nares, showing implication of the turbinated structures, or the posterior wall of the pharynx was coated with stringy mucus difficult to remove and simulating a false membrane.

Of the 550 cases specially examined, and of which notes were made, only twenty per cent. showed normal throats. In sixty per cent. of the cases there were adenoid vegetations, in twenty per cent. enlarged tonsils, and in twelve per cent. both of these conditions existed.

How shall we account for the great prevalence of these hypertrophic affections in this city? We are constantly meeting with, pertrophic rhinitis; abscesses in the ethmoidal

and frontal sinuses and in the antrum are far more common than in the more inland cities, while from the West we hear of the frequency of atrophic rhinitis. Is this not the result of the humidity of our climate? As I have mentioned above, on damp days with lowered barometric pressure there is a congestion of all the mucous membranes. Often repeated congestion leads to hypertrophy. Lymphatic tissues are more prone than others to increase of growth. The pharynx and nose are freely supplied with lymph-follicles. Here we have the whole process—humidity, lowered barometric pressure, congestion, hypertrophy of lymph-tissue, nasal obstruction, over-secretion of the mucous follicles, enlarged faucial and pharyngeal tonsils, granular pharyngitis—the catarrhal picture which we see so frequently.

The removal of enlarged tonsils, faucial and pharyngeal, in children by the tonsillitome and curette, or the galvano-cautery, is the accepted treatment. Should we not also destroy the growths on the posterior wall of the oro-pharynx in childhood, thus avoiding the disagreeable symptoms coming on in adult life as singers' and clergymen's sore throat and chronic pharyngitis? As we cannot change the climate, this seems the only available means of prophylaxis. Astringents produce no effect on the lymphoid growths. Acids are objectionable from their tendency to spread where their action is not needed. Bosworth commends the use of the galvano-cautery after applying cocaine, when it is nearly painless. It has also the advantage that your little patient does not know that the point is hot, as it enters the mouth before the current is turned on. You can allow him to feel the cold point and assure himself that there is no cutting to be done. I have found this method of treatment very successful in adults also.

I was surprised by the number of cases of divided uvula that I met with unaccompanied by cleft palate. These varied in degree from a double tip to a complete division up to the transverse fibres of the palate. Out of my five hundred and fifty cases four showed this condition, and a number of others were met with during the summer.

One child presented a very peculiar condition, resulting from an early attack of scarlatina. No tonsillar tissue was to be seen, this having been removed by abscess formation. The abscesses had perforated the anterior pillars of the fauces, leaving a hole on each side, which gave the effect of a festoon of mucous membrane on each side of the throat.

PROCIDENTIA UTERI IN A PREGNANT WOMAN.

By AARON JEFFERY, M.D.

I REPORT this case on account of its rarity, and also to show what a pregnant woman *may* undergo without having a miscarriage.

I was called to see Mrs. V—, a German by birth, aged thirty-six years, mother of two children, on June 6, 1892. I found her with complete procidentia of the uterus, the womb having been out for a week, so she said. The labia and uterus were very much swollen and inflamed, having a muco-purulent discharge. There was also a bloody discharge mixed with mucus from the os uteri.

The uterus was very tender and painful, and as she suspected that she was pregnant I decided to have consultation before taking any steps in the matter. Dr. R. B. James saw the case in consultation with me, and we both thought it improbable for her to be pregnant. We accordingly replaced the uterus at once, and kept it in position with absorbent cotton balls, saturated in equal parts of glycerine and extract of white *pinus canadensis*. After keeping her in bed for a week, and daily replacing the cotton balls, she was able to walk about without protrusion of the uterus. Before I saw her she had been doing general housework, carrying water and coal, cooking, &c. I was surprised when her husband saw me in October and engaged me to attend her during her confinement, which he thought would be in a month or two.

Shortly afterwards I was taken with typhoid fever, and Dr. W. A. Willson delivered her of a healthy, full-term boy, on January 14, 1893. At this time she is in better health than she has been for a year or more, and thinks she is again pregnant.

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

AUGUST 15th, 1893.

A CIRCULAR recently issued by the Board of the Health Department of New York seems worthy of more than ordinary attention, not only for the work it announces the Board's readiness to undertake for the medical practitioners of the city, but also, and chiefly, as heralding the assumption of what appears to be a new function in Boards of Health—that of giving to the individual physician the aid of resources ordinarily beyond his reach, and (if desirable at all) far more acceptable to him than an inspector's visit to his patient. To fight against the introduction and spread of infectious diseases, and incidentally to aid in the diagnosis by sending an officer supposed to be possessed of special experimental knowledge of certain forms of disease, have always, it appears,

figured prominently among the duties undertaken by this, and therefore presumably by other American public health authorities. But the present, so far as we know, is the first instance in which such a body has announced its readiness to facilitate physicians' practical daily work in any other way than by its own appearance on the scene in the shape of an official sent to represent it.

What the New York City Board now offers to do is to make bacteriological examinations in cases of diphtheria, and of throat affections so closely counterfeiting it as to prove puzzling to the physician and embarrassing to the household in which they may appear. All the family physician has to do is to remove from the affected surface, by means of a cotton swab, material which he is to place on a culture medium prescribed by the announcement, and send it to any one of a large number of conveniently situated designated depositaries, within twenty-four hours, or earlier, and by telephone if need be, he is informed of the result of the bacteriological examination—that is to say, of data on which he may found a positive diagnosis at a comparatively early period in the progress of the case. What trouble may thus be averted in cases of real diphtheria by enforcing the patient's seclusion and other necessary precautions, or, in cases that only simulate diphtheria, what needless alarm as to the result to the individual, and what uncalled-for abstention of other members of the family from attendance upon him and from free association with others, will at once be perceived by any family practitioner. It is a little remarkable that the light swabbing specified in the circular should be considered sufficient for a purpose so important; but presumably an authority which has at its command the best expert assistance obtainable in America would not take the responsibility of declaring a diagnosis—for practically that is what it amounts to—except on such data as the said experts have pronounced sufficient.

The new departure is received by the professional press of the United States with general approval, and may therefore be supposed to commend itself to medical opinion at the scene of its operation. To some minds, it would appear to prevent the objection that it introduces to an undesirable extent the principle of beaureaucratic interference in professional concerns. It is fair to say, however, that the ordinance appears to be permissive only, so that the no doubt numerous practitioners who are perfectly capable of making a bacteriological diagnosis, when necessary, for themselves, are free to do so. In the effete European mind there is rooted a somewhat severe prejudice against such an idea as diagnosis by Government Department. But still, if doctors in "the land of the free" prefer it, who shall say them nay?

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NEWS AND NOTES.

THE following from the Irish correspondence of *The Standard* will not fail to commend itself to the unfailing humour of our many readers among the profession in the Green Isle. We quote it *verbatim*, though to the italics, which do but accentuate the playfulness of it, we lay a modest claim:—
 “A Dublin correspondent telegraphs that Cardinal Moran is lying seriously ill in that city, and, although his condition does not give rise to immediate alarm, *much anxiety is felt from the fact that he has been under medical treatment since his arrival!*”

Apropos of the Fourth of July rejoicings in New York, *The Medical Record* newspaper of that city cheerily says: “The accidents were numerous, and make an interesting contribution to surgery and contemporaneous history; the total number reported was forty-one, which makes exactly one case of surgery to every fifty thousand of the population, assuming that all cases were reported. The favourite form of surgical celebration appears to have been a burn; there were seventeen cases of this kind of injury. Following very closely upon burns came gunshot wounds, of which there were seventeen. All parts of the body were perforated, but the lower limbs were in the majority, receiving eight shots, while the arms received four, the chest two, and the head three. No citizen of New York is reported to have been shot in the back. One person, we regret to say, was killed accidentally by a rifle shot, one was thrown from a waggon, one had his leg fractured, and two received lacerated wounds. We extend to the forty unfortunates our sincere commiseration. Fourth of July will come again, and another forty will be hurt, perhaps fifty. For there are two millions of people who escaped, and they must still have their celebration. Pope touched at the explanation when he said: ‘I never knew a man in my life who could not bear another’s misfortunes perfectly like a Christian.’ The unscathed millions are sorry, but they bear up, and buy more fire-crackers.”

BERLIN boasts of its four lady doctors already. Whether the profession will be further increased through female assailants remains to be seen; but if Herr Baumbach’s motion, which he brought forward lately with much eloquence in the Reichstag, asking that women be permitted to present themselves for the Staat’s Exam—with a view to practising medicine—is eventually carried, we can only imagine that the existing female practitioners will have their numbers largely augmented in Berlin as in other German towns.

A NEW occupation has been propounded by the Massachusetts Emergency and Hygienic Association—namely, the opening of a new occupation for young women who desire the cheerful task of becoming attendants upon chronic invalids, aged persons, convalescents, and sickly children. There are many families where it is inexpedient or impracticable for the relatively well members to wait upon those other members who may be feeble or sick. The trained nurse’s attentions are a step above what is required in such cases, and are, perhaps, too high-priced for a long-continued service, as in the case of a confirmed invalid. It is at the time when the trained nurse takes her departure that the trained attendant may often do much good. And some discipline and instruction will make the latter fit to take up the work of the former.

The Arena, which aspires to deal with the larger problems of existence, publishes an article on “Arsenic *v.* Cholera.” “By so taking arsenic,” says the writer, “we fix the albumen to such an extent that cholera (which does the same) cannot take hold, and thus cause, along with the loss of the salts, the cramps of the disease. By taking arsenic by mouth, hypodermically, or from ivory points, and repeating as necessary to produce this effect we destroy the animal and vegetable germs extant at the time of the exhibition of the remedy, and preserve the tissues from further and rapid carbonisation in consequence thereof; and as it is a reconstructive as well as a

tonic, we obtain immunity from the comma bacillus as long as forty days thereafter, making each person so arsenicised a non-infected and non-infectant medium daily growing stronger.” Voltaire somewhere says that magical incantations will kill a flock of sheep if a sufficiently large dose of arsenic be given at the same time; on the other hand, we have little doubt that arsenic will often protect from cholera—if assisted by a sufficiently lively faith. It is astonishing that editors of lay journals can be so deficient in prudence and intelligence as to allow the remarkable doctrines quoted to be published.

At a recent meeting of the Paris Hospital Medical Society, M. Marie showed the photograph of a woman with a supplementary mamma, and stated that nearly all the members of her family, for four generations back, had presented the same anomaly. Moreover, among her father’s fifteen brothers and sisters there had been six twins, and among her own brothers and sisters, twelve in number, eight twins. All these fourteen twins were of the male sex, showing that the tendency to beget twins could be transmitted through the male line. That the tendency to “twining” may sometimes reside in the father, and presumably act by virtue of some undiscovered peculiarity of the spermatozoa is illustrated by the case of Burns (the poet deceased, not the labour politician, happily still living, of that name) who became four times the parent of twins, two pairs “got betwixt the lawful sheets,” as the phrase goes in “King Lear,” and two pairs otherwise—a severe warning to the unchaste.



DR. JOHN RAE, F.R.S., F.R.G.S.
 From a photograph by Lyne & Co., Richmond.

READING before the recent meeting of the American Medical Association, Dr. W. H. Humiston, of Ohio, said that, after five years’ experience in the use of cocaine in gynecological operations, he felt better prepared to eulogise its merits now than he could do two years ago, when he first brought the subject before the Association in Washington. He had then stated that the only annoying symptom that frequently arose was the shortness of breath and the anxiety connected with it; this he had been able to obviate by the use of strychnia or tincture of nux vomica, one-thirtieth grain of former, or fifteen minims of the latter, administered with one half-ounce of whisky thirty minutes before operation.

He performed the following operations with no other anæsthetic than cocaine, viz., dilating, curetting, trachelorrhaphy, anterior and posterior colporrhaphy, and perinaorrhaphy, frequently making two of these operations at one sitting. The essentials of the methods were: asepsis, pure cocaine, quantity, and method. He prepared the cocaine in two strengths, four and ten per cent., the first for hypodermic use and the latter for intra-uterine injection preceding curetting. The quantity at one sitting varied from three-quarters to two grains. In the discussion which followed the general feeling was, however, decidedly adverse to the use of cocaine in this way.

UNDER the name of “Antipyrinomania” Dr. Cappelletti (*Revista sperimentale di freniatria e di medicina legale*, and *Revue générale de clinique et de thérapeutique*) writes of a mental affection caused by the use of antipyrine. A hysterical woman, twenty-three years old, had used the drug to excess for two years, to allay headache, taking every day as much as two drachms. She had become affected with loss of appetite, sleeplessness, tinnitus aurium, and muscular weakness. She entered a lunatic asylum of her own accord, to enable herself to abstain from antipyrine. The dose of the drug was reduced, but this produced such a state of prostration and such grave functional disturbances, even when the patient was unaware of the reduction, that potassium bromide and caffeine were resorted to. The patient was finally cured of these ill effects, and of her craving for antipyrine. The author recommends the gradual reduction of the dose in such cases.

IN a number of cases of hydrophobia recently occurring in India, so says *The Indian Medical Record*, the period of incubation has been found to be almost invariably three months. The disease has been noted especially in Calcutta, Bombay, and Benares, and stringent police measures are being enforced for the destruction of all stray dogs.

OUR ILLUSTRATIONS.

WE regret to record the death of
DR. JOHN RAE, M.D. (McGill College, Montreal), LL.D.
Edin., F.R.S., L.R.C.S. Edin., F.R.C.S.,
the celebrated rescuer of Sir John Franklin's remains, at his
residence in Addison Gardens, London.

The career of Dr. Rae might not unreasonably furnish an argument in support of the thesis that hardships and exposure, even in the extreme degree, benefit the health and prolong life. But it would be safer to conclude that a good constitution to start with, coupled with habits not less excellent, will carry a man safely through more than most people imagine, without impairment of physical strength. Certainly Dr. Rae's is a monumental case of extraordinary physical capacity in the extreme of age. His first qualification, as the Medical Directory shows, dated from 1833, he having been born two years before Waterloo, and he was a keen sportsman to the last.

His first Arctic voyage—and he made three in all—commenced on July, 1845. He afterward published, as everyone knows, a pleasing book of his wanderings, though it has always been regretted by his literary friends that he did not produce some more exhaustive or at least more adequate record thereanent. But his great achievement was the recovery of Franklin's remains, which earned him the unsought honour and advantage of the Government prize of £10,000 (offered after his departure to the Far North on that errand), and the rare honour of the Founders' Gold Medal of the Royal Geographical Society. An excellent shot, he was, until quite recently, constantly seen on the Scotch moors, wherein he never ceased to take delight, and at our Volunteer gatherings. A characteristic photograph of Dr. Rae, in Highland costume, was published immediately on his death. He was of an ardent, enthusiastic temperament, was tenacious of his opinion, and must have been in many minorities, but his sweet and genial disposition rendered it impossible for any differences to alienate him from his fellows. Of the Esquimaux, whose language, from long residence among them, he spoke with some degree of fluency, he held a high opinion, and he liked to dwell upon their virtues.

Commenting on his death, *The Lancet* says: "We cannot help feeling that if he had been a rich banker or brewer, or the head of some State department, but otherwise unknown to fame, he would probably have received titular distinction, and it is to be regretted that a man with such physical and mental energy, who had done such splendid service, should not have received what he had so richly earned." Possibly it was a sort of unconscious inkling of this sentiment that prompted *The Daily News*, at the head of its obituary, to give him brevet rank as "Sir" John Rae. But of such a man it might be truly said that he would have honoured a baronetcy more than the empty title could have honoured him. But, with his sturdy independence, though he would perhaps have appreciated keenly the nominal dignity of such a thing, it is probably truer to say, that in the consciousness of a great career, not unworthily closed amid "honour, love, obedience, troops of friends"—in the recollection of a great service to the nation's honour worthily rendered and as honourably appreciated—he found, and died happy in having found, the best of all rewards.

AMERICAN OPINION.

TRANSILLUMINATION OF THE MASTOID CELLS AS A MEANS OF DIAGNOSIS OF MASTOIDITIS INTERNA SUPPURATIVA.

By GEORGE W. CALDWELL, M.D.

WHEN we consider the serious nature of confined pus in the mastoid cells, the frequency of death from meningitis, thrombo-phlebitis, or metastatic abscesses resulting from recognised or unrecognised cases, the gravity of the operation for its relief, and the occasional operations which are done on a mistaken diagnosis in which no purulent collection is found, it is apparent that any means by which we may diagnosticate this disease with greater accuracy will be worthy of our careful attention.

Such a means will be found in the miniature electric lamp, and the conclusions to be deduced therefrom will be based upon the fact of the diaphanous nature of healthy mastoid cells and the opacity of pus; and the auxiliary proposition that however mastoids may differ in size, shape, and thickness, and therefore in transilluminability, they are practically at

least the same on the two sides of a given head, thereby affording an easy and accurate basis for comparison.

The apparatus required is a battery which will develop about ten volts—roughly speaking, a five-cell battery—regulated to light well, but not burn out, a two or three candle-power electric lamp of very small calibre, this being protected by thin rubber tubing fenestrated at one side and made to fit snugly at the meatus by a washer of larger tubing.

In a perfectly dark room the lamp is inserted well into the external auditory meatus, the fenestra directed backward, and the current made. Instantly the healthy mastoid is illuminated with a ruddy glow extending from the apex to the lateral sinus and to the limits of the cells above. The reverse manner may be more satisfactory in a given case, as when the canal is small, obstructed, or painful, and may be used with a larger lamp. A speculum of large size being placed as for examination of the membrana tympani, the electric lamp, incased in a rubber tubing projecting slightly beyond the lamp, is pressed against the mastoid and the current made, when the external auditory and middle ear will be filled with a rosy light from the posterior wall.

By placing the lamp on different portions of the mastoid the limitations of the cells and the position of the lateral sinus may be accurately mapped out, and the particular region in which a pathological process exists demonstrated. If the cells are occupied by a purulent collection, the glow will be absent and the cells will be dark. Comparison with the opposite healthy side renders the diagnosis of pus in the mastoid cells complete, whether or not the usual symptoms are present, for suppurative mastoiditis may exist without external indications, which, indeed, is the most dangerous form, as the process tends to extend inward, not outward.

D. Milton Green (*Journal of the American Medical Association*, November 12th, 1892) mentions five cases in which none of the external signs were present, no tenderness, pain, or swelling, yet pus was found either on the operating table or at the autopsy. Knapp has reported a fatal case (*Archives of Otolaryngology*, July, 1892, page 239) in which no discharge from the ear ever occurred. In a series of eighty cases reported by J. Orne Green, of Boston (*Journal of Medical Sciences*, 1890, page 575), 13 per cent. showed no external signs, yet confined pus was found. (See also report of forty-seven cases operated upon in Mount Sinai Hospital, New York, by Dr. Gruening, *New York Medical Journal*, January 2nd, 1892.)

Frank, developed cases are easily recognised, but the classical indications of Schwartz or of Körner, quoted with more or less modification in every text-book of otology, are of uncertain assistance in deciding a doubtful case. The method which I have herein submitted is scientifically accurate, easy of application, painless, strikingly pictorial, instantly decisive, and demonstrable to the patient's friends.

A CASE OF HOMICIDAL MANIA.

By ERNEST HELM, M.D.

PHYSICIANS are often called upon to listen to strange, humorous, pathetic, or horrible stories; but seldom has it been my lot to hear a more frightful one than a patient related to me last night.

He told it so simply and graphically that I can do no better than give it in his own words.

He is a carpenter, of powerful physique, while his wife is a delicate, slender woman. The events occurred about three years ago, and are strictly true, and illustrate to a remarkable degree the wonderful cunning of some insane patients. He said:

"My wife had often acted strange before, but had never attempted violence, so I was totally unprepared for what happened. We had retired as usual, when between 11 and 12 P.M. I was suddenly aroused from sound slumber by violent and repeated blows on the head.

"Frightened, confused, bleeding, I sprang from my bed, and in that hideous darkness I grappled with my unknown assailant. We had a fearful struggle for the mastery, when at last I wrenched a stout club from my opponent's hands, and was about to use it with all my force, when my wife laughed and said in her usual tone of voice, 'Ben, I had to do it.'

"Until she spoke I had no doubt but that I was assailed by a burglar or a midnight assassin. On lighting the lamp I found the club was a heavy hickory mallet-handle.

"A physician was called who treated my wounds, though I will bear some of the scars to my grave.

"Nothing new happened during the rest of the night, and the next night she went to bed as usual, while I kept watch.

My head pained so that I could not sleep, and anyway I dared not sleep.

"Early the next night she said, 'I want a drink,' and when I volunteered to get it for her, she savagely told me 'to mind my own business, she would get it herself.' I said, 'All right, suit yourself,' for I made it a point never to cross her, except when absolutely necessary, and then to be firm and unyielding.

"She arose, went to the water-pail in the next room, in plain sight of me, stood there rigidly for a brief time, and then suddenly went out of sight into the pantry. I at once arose to follow, when she laughed and returned to bed. Wondering what her object could be in going to the pantry I determined to investigate when she went to sleep. Soon she became quiet, her breathing deep, and regular, so I feigned sleep by nodding in my chair, closing my eyes, and allowing my paper to fall to the floor. Through my half-closed eyes I watched her; she soon half arose, her eyes gleaming like a snake's, and eyed me intently. When I aroused she dropped back in bed in her former position so quietly and suddenly that I doubted my senses as to whether she had ever stirred. After a while, feeling sure she was asleep, I went out through the kitchen into the pantry, and my blood ran cold when I found two large butcher knives laid out for me. Returning to see if she still slept, I found her apparently as I left her, so I went again to the pantry and took the knives out of doors and threw them away in the grass.

"All this time I heard no sound, and it was impossible for her to see me from the bed or the room where she was.

"Her brother afterwards soon came, and, as she still slept and I was very tired and in great pain, I arranged for him to watch her, cautioning him not to close his eyes for one instant. I then went upstairs, but the floor had settled so I could not quite shut the door. I dared not go to sleep with an unlocked door, so I took a large stove zinc and noiselessly placed it against the door, in such a position that the door could not be opened without knocking the zinc over and thus arousing me. I slept little, but toward morning I fell into a light sleep, but soon awoke, feeling that someone was climbing the stairs. I listened intently and soon knew she was coming. She approached the door, and though it was opened only two inches (and from the inside, so a person on the outside could not see the zinc at all) her slender hand and arm crowded in, grasped the zinc, and noiselessly removed it. I then said, 'What do you want?' She laughed and said she wanted me 'to get up for breakfast.' She then descended the stairs, and forgot to take the large carving-knife she had carried up to use on me. She had laid it down when opening the door. I found her brother was sound asleep.

"It was now 4 A.M. and quite light. She had had him build the fire and go to bed, while she busied herself getting breakfast. I then went out to secure the knives in the grass. She came to the door, so I pretended to be out to view the beauties of the early morning sky; but she said: 'Oh, I brought those knives in an hour ago.' This startled me greatly! How did she know those knives were there? The grass was too long to find them by accident. She could not have seen me from her room or bed when I threw them out, and I am sure she remained in bed.

"Then how did she know the zinc was against my bedroom door? I placed it there noiselessly, and it could not be seen from the outside. She was soon adjudged insane and sent to the hospital for the insane.

"I see her often now, and while sane on many points, and often asking me to take her home, she will never promise not to assault me.

"She only says that 'she cannot bear to have me buried alive, and if she does not kill me I will surely be buried alive.'

"Oh! it was a terrible experience, and her first midnight assault was so deadly and hideous that I shudder whenever I think of it."

This experience is worse than many of the terrible things in fiction, but I can personally vouch for every word of it.

THE TUNING FORK AS A REMEDY IN EAR DISEASES.

By JOSEPH SIMROCK, M.D.

THE vibrations of a tuning fork, by interposing a slender staff as conductor, can easily be transferred on a stretched elastic membrane. The membrane can thus be made to produce a sound corresponding in pitch to the rate of vibrations of the tuning fork.

The membrana tympani, being a stretched, elastic membrane, if connected by a conductor with a vibrating tuning

fork, is influenced in the same way, and this physical process can be made useful in a therapeutic sense.

A fine, elastic probe, the end of which has been covered with some cotton to prevent its point from protruding, is pressed slightly against the drumhead. By bringing this probe now in contact with the vibrating prong of a tuning fork, the membrana tympani commences to vibrate, producing a sound audible at some distance, and varying in pitch by using tuning forks of different rapidity of vibration. This sound is of various loudness, sometimes even in both ears of the same individual, with no visible changes in the drumhead to explain this difference, which may depend on pathological changes—as folds or bands in the drum cavity, thickening of the mucous membrane, or changes in the quantity of air contained behind the drum membrane.

These strong vibrations of the membrane, caused by the vibrating tuning fork and conveyed on the chain or ossicles and through these on the membrane of the fenestra ovalis, can exercise a curative influence on these parts in diseases impairing their natural mobility—as in progressive sclerosis, in chronic catarrh, in the later stages of acute and subacute catarrh, also after suppurative diseases.

After trying the different kinds of tuning forks on their utility, I make now chiefly use of two—one with round, cylindrical prongs, the latter eleven inches in length and about one-fifth of an inch in diameter; the other also with cylindrical prongs, seven inches long and one-fourth of an inch thick. The sound produced by the larger one corresponds in pitch to the low C of the bass, that produced by the smaller to the low E flat of the tenor voice. By using more or less pressure in applying the probe to the drumhead, or by exciting the tuning fork into vibrations of more or less amplitude, the strength of the appliance can be modified.

Even in far-advanced cases of deafness caused by the above-cited ear diseases, a decided and permanent improvement could thus occasionally be made. Better results were observed in cases where ordinary conversation could be still understood in not less than four feet distance.

Cases of osseous ankylosis of the stapes, or ossification of the membrane of the fenestra ovalis, will be benefited as little by this as by any other known procedure.

Tinnitus sometimes, after a few treatments, ceases entirely; in other cases it stops for a short time, to return in the same or a milder form; still other cases remain uninfluenced.

In making use of this procedure I would recommend beginning with weak vibrations and treatments of short duration, and gradually increasing both.

A PIN IN THE TRACHEA.

By HERBERT W. CARDWELL, M.D.

THIS report is made simply to add to the existing literature on the subject of foreign bodies. On January 18th, 1893, I was called to see Miss Mary P—, a domestic in a family residing about three miles out of town. On arrival I learned that about two hours previously, while dressing, she had placed a pin in her mouth, and, becoming startled by a knock at the door, had swallowed it. She was rather excited, and was not sure what kind of a pin it was, or how she had placed it in her mouth, head first or point first. Careful laryngoscopic examination failed to discover it, although she claimed to feel sharp, sticking pains just below the larynx. She was sent to the hospital for observation, and kept at rest on a diet of bread-and-milk. On the following days she complained successively of pain in the larynx, mediastinum, left epigastric region, umbilical region, and right epigastric region. Then the pain disappeared, and after ten days in the hospital she insisted upon returning to her home. There had at no time been any indication for operation, especially as the patient objected strongly to such a procedure. After her return home she applied for treatment for a chronic uterine trouble, and from time to time spoke of the pin, and wondered what had become of it. On April 23, 1893, she had a severe attack of coughing and ejected the pin, point first. On examination it proved to be a steel shawl-pin, an inch and a half long, and with a conical black head, three-sixteenths of an inch in diameter, and, while much corroded, still very sharp. Upon returning the pin for examination she admitted that since the ingestion of the pin she had been subject to cough, chiefly nocturnal, which was of an irritative character and gave the impression of a foreign body in the larynx. The sputum has been from time to time streaked with blood. There has been no pain since leaving the hospital. Since the ejection of the pin she feels no discomfort.

Where has this pin been for the last ninety-five days? I thought I was justified in believing that the pain in various

points on successive days indicated a progressive advance on the part of the pin along the alimentary tract. Its ejection by coughing at such a late day seems to imply that it has been at some point in the respiratory tract all the time. Inspection of the pin would make anyone sceptical regarding the possibility of such a foreign body remaining in any portion of the respiratory tract for any length of time without causing trouble, and yet, for ten days at least, there were no symptoms of irritation of either larynx or trachea.

DERMOID CYST OF THE RIGHT OVARY, FOLLOWED BY GANGRENE OF THE FALLOPIAN TUBE AND OVARY, CAUSED BY A TWISTED PEDICLE.

By R. EMMETT GIFFEN, M.D., Colonel and Surgeon General, National Guard, Nebraska; Surgeon in Chief of St. Elizabeth Hospital, Lincoln, Nebraska.

IN reviewing the literature of ovarian tumours I find but one case mentioned—that by Thornton—of gangrene caused by twisting of the pedicle. And there is some doubt in that case from the fact that it followed surgical interference. In the case I am about to report there was no surgical interference until the patient was placed on the operating table.

Maggie S—, aged twenty-eight, multipara, single, was admitted into St. Elizabeth Hospital, August 8, 1892, in the medical department, suffering from pain in the lower part of the abdomen. Temperature, 102°; tympanites, &c. Five days later she was transferred to my department. I obtained from her the following history:—She had always enjoyed fair health up to five years ago; she had a child at that time. One year after had gonorrhoea, followed by so-called "inflammation of the bowels;" was confined to bed for six weeks. For one year after that, with the exception of during her menstrual period, she was free from pain. For the past three years has suffered continually from pain in the right side, especially while at work, her occupation being that of a domestic. About a year ago she says that she felt a lump in the right groin, and while at stool it broke, and she passed considerable pus by the vagina, and continued to pass pus at intervals up to within a few days of her admission into the hospital.

At that time, while in the act of lifting a bedstead, she felt something that seemed to turn in the right side, and she was seized with the most excruciating pains in the right side and in the uterus and vagina, as if something was pulling the rectum and vagina. I saw her five days after her admission, and eight days after, as she termed it, her injury.

I examined her and found an enlarged tube and a cyst of the right annexa with abscess, and advised abdominal section. My wish was readily complied with, and on the following day, assisted by Dr. Britt, Dr. Grimes, and Dr. Beebe, I opened the abdomen (it is understood that in all my operations everything is rendered thoroughly aseptic) and found a twisted pedicle, twice round, of the Fallopian tube, of a blackish-gray appearance, and so friable that in attempting to lift it up it tore to pieces, although the slightest force was used. I then enlarged the opening in the abdominal wall and passed my hand down into the pelvic cavity, and found a cyst with a pedicle attached to the vaginal wall and twisted in like manner to the one attached to the uterus. I separated it from the vaginal wall, knowing the opening in the vagina would be a good point to drain through.

After removing the tube and ovary of the opposite side, there being a cyst of about the size of an egg in the left ovary, I washed the peritoneal cavity out thoroughly with hot water, put a drainage-tube through the opening in the vagina, and closed the abdomen. First of all, let me say that I always sew the peritonæum separately with a fine catgut continuous suture, then the muscular tissue in like manner, then use the interrupted suture, involving all the tissues save the peritonæum.

The patient rallied from the effects of the operation satisfactorily, and that night, while the nurse was absent from the room for a few moments, she got up out of bed, walked across the room, and, picking up a pitcher of water, drank copiously. Of course the result was an attack of vomiting, which lasted several hours. On the following day her temperature was 101° F., and she complained of gas in her abdomen, which continued for five days, in spite of all remedies used. Her temperature never reached a point higher than that of the second day. I removed the drainage-tube on the third day. She continued to improve; on the fifteenth day after the operation was sitting up, and on the twenty-first day left the hospital,

feeling quite well. On opening the cyst, I found it to be a dermoid cyst, full of pus, with an opening in the twisted pedicle at the lower end—the one that communicated with the vagina. It also contained a piece of bone, a tooth, and a bunch of hair. The gangrene involved the Fallopian tube and part of the ovary. The cause of the gangrene can very readily be explained by the passage of air through the opening into the vagina to the abscess in the cyst; then the twisting of the pedicle by the turning of the cyst, cutting off all blood supply.

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

APPENDICITIS IF SEEN EARLY.—Absolute rest, fomentations, salines every half hour until four or six fluid stools are produced.—Jonas.

CREOSOTE is no longer an innovation or a fad, but a drug which has come to stay as an antitubercular remedy. It is particularly valuable in the earlier stages of tuberculosis. Its administration must be in moderate doses for a prolonged period. It is a safe and reliable prophylactic in the condition that is usually described as pretubercular anæmia.—Stark.

BORIC ACID, in daily dose of fifty to seventy-five centigrammes after a purgative dose of castor-oil containing five or six drops of turpentine, has been found by Torchinsky to diminish diarrhoea, tympanites, and fever in typhoid.

CHOLERA.—Chloral, by hypodermic injection, has been extolled. The following is a suitable formula:—

R Chloral hydra.	...	...	...	...	5 iij.
Morphin. sulph.	...	...	...	...	gr. j.
Atropin. sulph.	...	...	...	...	gr. 4.
Aque chloroformi,	...	...	...	...
Aque	...	...	...	...	aa 3 ss.

M. Sig.: Twenty minims, repeated in ten minutes, and subsequently *pro re nata*.

—Bartholow.

CEREBRAL ACTION OF SOME MEDICAMENTS.—Kroepelin says that a given drug has a different action on sensory and motor functions. Thus: 1. Alcohol in small doses impairs the sensory functions and excites the motor ones; in large doses it first aids the motor processes, then abolishes them. 2. Paraldehyde causes difficulty of the sensory functions and aids the motor processes, then rapid paralysis of these last. 3. Chloral impairs both sensory and motor functions. 4. Ether rapidly paralyses sensory processes and excites motor; in large doses it increases the sensory paralysis, and eventually abolishes motion. 5. Chloroform has a similar but more rapid action. 6. Amyl nitrite causes excitement of the motor functions, slight paresis of the sensory processes. 7. Tea greatly facilitates sensory processes, after a time depressing them, but has little effect on the motor functions. 8. Morphine causes at first enormous excitation of sensory functions, but subsequent rapid depression; it causes marked and persistent paralysis of motor functions.

DIABETES.—The beneficial effect of codeia in controlling the amount of sugar has long been known. Bruce has shown that morphine may act equally well in some cases. Ralfe prefers the latter because of its uniformity and greater power, but believes that to obtain the full benefit of opium some of its other derivatives should be combined with the alkaloids. Thus acetate of morphine in solution may be added to liquor opii. Lyzygium Jambolanum in dose of a gram and a half to two grams daily, increased every third day to four, six, eight, ten, twelve grams, and so on for a month or more, or until the patient had taken two hundred grams of the liquid extract, corresponding to one hundred grams of powdered seed, was given to a diabetic patient by Drs. Raimondi and Rossi (*Gaz. Med. Lomb.*, January 16th, 1892). Polyphagia was diminished; polydipsia and polyuria not so much. Sugar decreased from twenty-five to twelve per cent. There was gain in weight and general improvement.

INDIAN HEMP, in ten minim dose of the tincture three times daily, is almost a specific in insanity in women due to mental worry or moral shock, and is also of great value in mania and melancholia.—Suckling.

GALL-STONE COLIC is treated by Thudichum with morphine subcutaneously and large quantities of very dilute lemonade. If collapse threatens, chloroform anæsthesia is recommended,

UNIVERSAL PRURITUS has been relieved by Lange with internal administration of bicarbonate of sodium along with lithium carbonate. For itching in the genital region, carbolic acid compresses were employed.

VERATRUM VIRIDE is considered a safe drug and a sure remedy in scarlet fever, and it is thought that some cases may be aborted by its timely use.—CHAMBERS.

SULPHO-CARBOLATE OF ZINC is recommended by Sangree in typhoid as capable of rendering the mucous membrane and intestinal contents less suitable for the development of micro-organisms. It is of little use to employ small doses, and five grains are given by the author every three or four hours until the temperature falls.

THYMOL is a useful addition to carron oil in treatment of burns, from one-twentieth to one-tenth per cent.

OVARIAN NEURALGIA.—

R. Tinct. digitalis ... 3 j.
Tinct. gelsemii ... 3 ss.
Potassii bromidi ... 3 ss.
Aquæ ... 3 vj.

M. Sig.: Tablespoonful in water every three hours.

—Record of Medicine and Surgery.

ZINC GLUE.—Dr. Trentler recommends a preparation, first suggested by Unna, for stiff surgical dressings suitable for fractures and dislocations:

R. Oxide of zinc ... 10 parts.
Gelatine ... 30 parts.
Glycerine ... 30 parts.
Water ... 30 parts.

Apply thickly, rubbing in'o the muslin or gauze forming the bandage.

THE USE OF FLAME IN SURGICAL WOUNDS.—M. Félizet brought this subject under the notice of the Société de Chirurgie in October, 1892, alluding more especially to the difficulty experienced oftentimes in thoroughly eradicating tuberculous tissues in operations. The method of applying extreme heat which he adopted was the rapid passing over the tissues of a blow-pipe flame. Micro-organisms are thus destroyed, and healing hastened; the tissues become dehydrated completely, but never cauterised, unless the action of the flame upon them be prolonged beyond what is proper. During this proceeding the lips of the wound are to be protected by moistened compresses. There is commonly no reaction, no pain (*sic*), nor loss of blood; union may be expected by first intention. If suppuration occur, it should be taken as indicating that the "flaming" has been incompletely carried out.—*Boston Medical and Surgical Journal*.

CORRESPONDENCE.

SIR,—I have been prescribing Lactopeptine for many years, and cannot say too much in praise of it, in suitable cases of dyspepsia, no matter from what causes arising, in young or old, but I may say I find it very beneficial in young children of strumous diathesis, and consequently have got it placed upon our special list for "Special Medicines" for the Infirmary and Fever Hospital. In fact, I may say, I have reared children who were dying of inanition in the Workhouse by its valuable assistance alone. Again, in Alcoholic Dyspeptics I have had too great a success, as when they require it now, they know what to get without my seeing or prescribing for them.

I am, yours faithfully,

JNO. J. DURGNAN, M.R.C.S.I., &c.,

Medical Officer, Edenderry Infirmary and Fever Hospital,
Consulting Medical Officer of Health, Railway Medical.

June 19th, 1893.

BACK NUMBERS OF MEDICAL REPRINTS.

The following issues are out of print:—

No. 1 (February, 1890). No. 14 (March, 1891).
No. 7 (July, 1890). No. 17 (June, 1891).
No. 10 (November, 1890). No. 19 (August, 1891).
No. 13 (February, 1891). No. 22 (November, 1891).

Any other back number will be sent post free to any medical man on receipt of three penny stamps.

[For contents of numbers dated earlier than February, 1893, see former issues of MEDICAL REPRINTS.]

No. 37 (February, 1893) contains:—

Were Protoplasmic Reversions checked by Alcohol? By Wm. H.

Pearse, M.D. Edin., &c.; Early diagnoses of Mastoid Disease. By D. Milton Greene, M.D. (With an Illustration.)—Diseases of the Frontal Sinus. By D. N. Rankin, A.M., M.D., &c.; Case of Ununited Fracture of the Femur. By W. Tracy, M.D.; Medical Literature.—I. A Book of the Month. Reviewed by J. E. Bullock, M.D. Brux, M.R.C.S. Eng., &c.; News and Notes.—American Opinion.—Therapeutic Notes.—Portrait: Dr. William M. Polk.

No. 38 (March, 1893) contains:—

Constipation. By J. D. Staple, M.R.C.S. Eng. (Original Article.)—How Amputation of the Breast for Carcinoma should be Performed. By Prof. R. F. Weir, M.D. (With Two Illustrations.)—Spontaneous Cure of Multiple Papillomata of the Larynx after Tracheotomy; with the rare Anomaly of Papilloma of the Epiglottis. (With Four Illustrations.)—Medical Literature.—II. A Book of the Month. Reviewed by E. A. Piggott, L.R.C.P. and S. Edin., &c.—Books.—News and Notes.—American Opinion:—Digitalis in Pneumonia; Barium Chloride in Epilepsy: How to Cure Eczema.—A New Disinfectant Soap.—Therapeutic Notes—Views: The Bristol Medical School: Exterior, Entrance Hall, and Lecture Theatre.

No. 39 (April, 1893) contains:—

Cylindroids, or so-called Mucous Casts. By M. Manges, A.M., M.D. (With Six Illustrations.)—A Gynaecological Study. (Original Article.) By E. A. Piggott, L.R.C.P. and S. Edin., &c.—Some Physiological Experiments with Magnets. By F. Peterson, M.D., and A. E. Kennelly, Electrician. (With Four Illustrations.)—Relation of Rheumatic Fever, Heart Disease, and Chorea. (Original Article.) By W. Downing, L.R.C.P. London, M.R.C.S. Eng.—Books.—American Opinion.—News and Notes.—Medical Literature.—III. A Book of the Month. Reviewed by J. D. Staple, M.R.C.S., &c.—Therapeutic Notes.—Correspondence.—Illustrations: The Königl. Charité, Berlin. Four views.

No. 40 (May, 1893) contains:—

Dyspepsia Among the Textile Trades Operatives, its Causation and Treatment. By J. A. Diggle, L.S.A. Lond. (Original Article.) On the Importance of Examination and Flushing of the Genital Tract Directly after Labour. By Alexander Duke, F.R.C.P.I., &c. (Original Essay.) The Result of Examinations of Sewer Gas which Escaped in Tenement and Private Houses, wherein Cases of Diphtheria Occurred. (With Three Illustrations.) Cylindroids or So-called Mucous Casts, concluded. (With Three Illustrations.)—News and Notes.—Medical Literature.—IV. A Book of the Month.—Books.—Glycerine in Constipation.—American Opinion:—Internal Urethrotomy. Therapeutic Notes.—Correspondence.

No. 41 (June, 1893) contains:—

Urethral Fever. By P. Macleod Yearsley, M.R.C.S. Eng. (Original Article.) Three Cases of Syphilis. By J. A. Diggle, L.S.A. (Original Article.) Osteitis Deformans. By H. Ling Taylor, M.D. (With Five Illustrations.)—Vaginodynia. By E. F. Frost, M.D. Case of General Dyscrasia. By F. P. Emerson, M.D.—Books.—News and Notes.—Continental Practice.—American Opinion.—Therapeutic Notes.—Portrait: The late Prof. Marcus Beck.

No. 42 (July, 1893) contains:—

Proper Duration of the Lying-in Period. By H. Seymour Houghton, M.D., &c. Tattooing and its Removal. By Professor A. H. Ohmann-Dumesnil, M.A., M.D. (With Two Illustrations.) Case of Uterine Inertia, &c. By H. G. MacLagan, M.B., &c. (Original Article.) Internal Use of Hot Water in the Treatment of Disease in Infants. By H. S. McConne, M.D., &c. Varicocele, with Report of Nineteen Operations. By B. Merrill Ricketts, M.D., &c. Theory and Practice in Treatment of Syphilis. Treatment of Sprained Ankle. By P. C. Barker, M.D., &c.—News and Notes.—Use of Carbolic Acid in some Affections of the Eye. By G. Herbert Burham, M.D., F.R.C.S. Edin.—American Opinion.—Therapeutic Notes.—View: The Sisters' Hospital, St. Albans.

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MEDICAL REPRINTS

Home, Foreign, and Colonial: with Original Essays.

VOL. IV.]

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[No. 44.]

ENGLISH CHOLERA—ITS CAUSE AND TREATMENT.

By WILLIAM DUNCAN, L.F.P.S.Glas., &c.

[An Original Article specially written for MEDICAL REPRINTS.]

As we have been lately visited by a serious epidemic of English cholera in various parts of the country, might I ask space in MEDICAL REPRINTS for a few lines as to the etiology and treatment of the complaint?

I believe it is the generally accepted opinion that the disease is due to the ingestion of indigestible and unsound food, but from experience I am inclined to classify such a diet as a secondary cause.

Having investigated many cases during the late epidemic, where patients were previously particular as to the soundness and kind of their food, I was unable to obtain any history of their having changed their usual or former dietary, yet the complaint showed itself in some of such cases in its worst forms.

I am of opinion that the continuous high temperature of the atmosphere, together with the effluvia from the ground generated thereby, are the primary causes of the disease. The miasmatic poison, having entered the system, sets up indigestion and fermentation of the contents of the stomach and bowels, such fermented contents acting as severe irritants to the various parts of the digestive tract cause vomiting and diarrhoea, and the morbid impression made on the nerves of the alimentary canal by such a stimulus may be conducted to the spinal cord to be there reflected to various motor nerves, producing muscular spasm or cramp.

The following line of treatment has reference only to adults, and may be considered under the heads of prophylactic and curative:—

In order to ward off an attack the following points among others should be attended to:—Dwelling-houses and everything in and about them should be kept scrupulously clean and in as sanitary a state as possible, personal cleanliness should be observed, and all unhygienic conditions removed. Such food only should be taken as is easily digestible, and after every meal Lactopeptine (Richards) in appropriate doses should be used as, in my opinion, it assists materially the digestive process. I would also advocate the taking of quinine to counteract the effect of any miasmatic poison that might possibly find its way into the system, and the body should be kept as cool as it can be while the atmospheric temperature is high.

When the disease has been established, Nature begins to expel the offending contents from the stomach and bowels by vomiting and purging; and this natural eliminatory process has usually gone on to such an extent before we see the patient, that the exhausted condition of the latter demands the speedy arrest of the evacuations. Under such circumstances, then, a warm mustard poultice should be applied to the epigastrium, to control the vomiting, and small doses of morphia, with some preparation of bismuth, may be given. Swallowing small pieces of ice will be grateful to the patient, and assist in allaying the retching. Iced milk, alone or mixed with a little Kali water, may be taken occasionally in small quantities, and, when the stomach has been restored to a quiescent state, give astringent medicines to check the diarrhoea. A morphia suppository will be found useful when there is much tenesmus, and a little tinct. capsici added to the diarrhoea mixture often proves serviceable. The cramped legs require friction with some liniment, such as chloroform, or bathing them in warm water may give relief, and, by causing an increased flow of blood to the lower extremities, will tend to prevent congestion of internal organs.

During convalescence the stomach should be gently stimulated to healthy action by some simple bitter taken before meals, particular attention being paid to the quantity and quality of the food; and I would also give Lactopeptine after every meal, to which may be added a little pul. rhei and sodæ bicarbonas to aid the function of the liver.

NOTES OF SEVEN CASES OF DYSPEPSIA.

By J. A. DIGGLE, L.S.A.Lond.

[An Original Article specially written for MEDICAL REPRINTS.]

A COMPARISON of the treatment of dyspepsia, as given in some of the older text-books with what can be seen in modern ones, reveals at once a striking difference, and this difference is chiefly due to the general increase in the use of digestive aids, consisting of extracts or ferments isolated from the digestive secretions of animals.

When pepsin, obtained in its purest and most powerful form from the stomach of the hog, was first brought forward, it was generally recognised as a great boon to the medical practitioner, and was vaunted as a cure for every variety of stomach disorder. In the form of powder, pills, wine, and even in sauces and table salt, it stared you in the face from every advertising page. Further and more extensive trials showed, however, that it was not always to be depended on. Differences in quality, some sorts almost inert, and more critical study showed that in some cases it was practically of very little use.

Then it was recommended that hydrochloric acid should always be combined with it, as it only acted in acid states of the stomach. This increased its therapeutic value to some extent, but not much. The class of cases most benefited by the combination was the same as the pepsin alone did most good to.

That is to say, in simple cases of indigestion from over-eating or unsuitable food and those in which the stomach itself suffered from want of tone. In those numerous cases in which the intestinal secretions were at fault, all that large class in which fats were not tolerated, pepsin failed to give relief, and those where the eructations smelt of rancid fat and in which starchy foods were not well borne, were also unrelieved.

Under these circumstances chemists again turned to the animal kingdom to find some other ferment which should supplement pepsin. The secretion from the pancreas, which physiologists said helped in the small intestine to digest fatty foods was tried, and pancreatine was isolated.

In this case it was found that the ferment, unlike pepsin, acted better in an alkaline solution than either an acid or neutral one.

This, again, fulfilled some of its objects, and with the preparation of diastase, from malted cereals, relieved innumerable cases of dyspepsia, which pepsin alone had failed to do.

The combination of these three together in the drug well-known as Lactopeptine (Richards) proved very efficacious, the full formula being as follows: Pepsin, 8 ounces; pancreatine (pure), 6 ounces; ptyalin (diastase), 4 drachms; lactic acid, hydrochloric acid aa, 5 fluid drachms; and sugar of milk, 40 ounces. This combination contains, as will be seen, all the chemical elements of complete digestion.

In atonic and atrophic dyspepsia Lactopeptine is invaluable, and no kind of dyspepsia but benefits by its use, resting as it does the, in many cases, worn out and almost secretionless stomach, and digesting the food as if the organ were in good health. It thus enables us to give food in many cases which without it would have to be fed with enemata, or, in default of the latter, have to suffer semi-starvation. In fact, for some time I have made it my sheet-anchor in the treatment of dyspepsia, and most of the cases I note below owe their favourable termination to its use.

The ptyalin it contains helps the digestion in persons in whom the teeth are deficient, and who therefore cannot masticate their food properly, and so mix it intimately with the saliva. The lactic and hydrochloric acids give the stomach that acidity without which the pepsin fails to exert its full influence. The pancreatine helps to digest the fats, and so allows the full benefit to be got from the food ingested.

Over and above its normal digestive action, I have found it of benefit in the vomiting of pregnancy, and in a case which I report below it acted exceedingly well in relieving that so often distressing condition in women.

Combined with morphia, in cases of cancer, it undoubtedly relieves the urgent symptoms, and gives ease when no cure is possible. In infantile diarrhoea and sickness it acts like a charm, and if the stomach is too irritable to take the ordinary food suitable in such cases, a small quantity of Lactopeptine (gr. v.) placed in the milk before feeding the child, and allowed to act for half an hour, will, in most cases, result in the food being retained, and will in a short time give much improvement.

Having shortly given the chief characteristic uses of these remedies, I will now instance a few cases in which I have used them with benefit. Most of these have been treated with Lactopeptine.

CASE I.—Mrs. A—, a thin, delicate woman of about forty-five years of age, came to me on recommendation of Case V. She had had a slight paralytic stroke twenty years ago, caused, she said, by a blow from her husband (since dead of phthisis), and one arm was almost useless, the digits drawn up (flexed) and sinews contracted, the leg of the same side drags as she walks. Notwithstanding this, she has to get her living by washing. Her children are all strumous; one lad is an imbecile, and her eldest daughter, seventeen, is no bigger than a healthy girl of eleven. Another son has Morbus Coxæ and has been in the local hospital for six months. Mrs. A— has suffered from dyspepsia for years, and even if she could get good food, which many a time she cannot, she is afraid to eat it. Whilst going to the hospital with her son, the house surgeon noticed how ill she looked, and gave her several bottles of medicine, but she says with little benefit. Mrs. W— (Case V.), who had got great relief from the medicine I had given her, sent Mrs. A— to me. Her tongue was extremely foul, bowels constipated, and general malaise and inconvenience after food. I gave her a mixture containing:—℞ Lactopeptine ʒiij, Sp. Chlorof. ʒj, Tinct. Nucis Vomica ʒij, Aq. ad. ʒviiij, ʒss., t.d.s., and advised her as to food &c., of which she said her staple was bread and tea (butter she dare hardly touch). I ordered cocoa in lieu of tea, and milk as much as she could get; and told her to come again in a week. She did so, and was much relieved. Constipation had been a troublesome symptom, so I substituted Glycerine ʒj for the Sp. Chlorof. and repeated the mixture. She came three times in all, and the last time she said her tongue had not been so clean for two years; hitherto it had always been white or yellow, thickly furred, and with a most unpleasant taste in her mouth. How long the improvement will last it is of course impossible to say.

CASE II.—Mrs. B— I casually mentioned in my article on dyspepsia in MEDICAL REPRINTS for May. Her attacks of dyspepsia seem to have always culminated in acute gastritis, and when I saw her first her condition seemed serious, acute pain, vomiting, &c., being present. A hypodermic of morphia, gr. ¼, relieved the pain, and I kept her on iced soda-water and milk for a day or day and a half until the stomach settled, together with 15 grs. doses of Lactopeptine. She has had no such severe attack since up to time present, but has always a few powders of Lactopeptine by her, one of which she takes if her stomach troubles her at all. She says her stomach is now stronger than for many years past.

CASE III.—E— H—, a tall, thin young man of nineteen years of age, sallow, and "bilious" looking, a factory worker with evident signs of too rapid growth, was brought to me by his mother in great fear of consumption. Being a mule spinner, he had to work in a very hot room, and at his work was only half clad. They wear nothing but a shirt and linen overalls. His appetite was bad, tongue foul, and he had a dry tickling cough. Bowels very costive. On careful examination I found no signs of any lung mischief and concluded it was a case of mal-nutrition from dyspepsia. I gave him a soda and rheum mixture with some powders of Lactopeptine, gr. x. in each. Under this treatment his tongue got cleaner and the bowels more regular, and after a week I gave up the rheum mixture and put him on one of Lactopeptine lx. grs. with glycerine ʒj in ʒvi of water.

In a month he was decidedly better, the cough had almost left him, and he was beginning to put on flesh. In two months he was very different from when I saw him first, no cough, appetite good, and a stone heavier. He is now quite strong and about to be married.

CASE IV.—Curiously enough the woollen-operatives do not suffer to the same extent as the cotton from dyspepsia

and allied complaints; in fact, they are generally fat and robust, but this case was one of them. He, however, worked in the packing-room, which was cold and draughty. H— B— presented all the usual features of a dyspeptic subject. He had suffered from it for years, and told me he dared not eat a piece of meat at all, and vegetables but rarely, except in broth. His diet consisted of milk, eggs, and bread-and-butter and cocoa.

He improved rapidly under treatment by Lactopeptine, and now gets it himself from the chemists and dusts it over his food as others do pepper.

He told me of something which shows how much rubbishy pepsin is sold as genuine stuff. After he had finished his first bottle of Lactopeptine he went for another, but the man to whom he went had sold out. Wishful to have some that day he went to another shop, where the shopman said they had no Lactopeptine, but they had something just as good; and gave him some pepsin, which turned out a very poor sample, but for which he charged as much as for Lactopeptine. Mr. B— told me it "fairly stunk," and it was so disgusting to the taste that he had to throw it away. However, he got his old remedy in a day or two, and with its help can now eat a hearty meal of meat and potatoes.

CASE V.—Mrs. W—. This woman keeps a small confectionery and cooked meat shop, and also makes dinners for the factory hands. She almost always suffered from indigestion after baking, even though not eating any new bread, and her appetite was very capricious.

She improved rapidly under the new treatment, Lactopeptine, &c., and after two bottles said she felt "new made over again." Twice since her first call on me has she been for more medicine. She is a careful, rather niggardly, woman, and gave up the treatment before she was really quite well.

CASE VI.—Annie N—, niece of the foregoing and her assistant in the shop, was also a great sufferer from dyspepsia. She, however, is a thin, pale, delicate creature, whilst the aunt is broad-set and strong. Annie's father died of phthisis, and great fears were entertained of her following him. However, no chest mischief has as yet developed.

She was greatly benefited by the Lactopeptine, and has since taken ext. malt and cod-liver oil. She says the Lactopeptine enables her to keep the oil down.

CASE VII.—Mrs. A— came to me suffering from severe vomiting in a morning. She was nearly two months gone in pregnancy of her third child. Had always suffered slightly from sickness, but never so severely as now. Cocaine jelly did not stop it, so I gave her five grains of Lactopeptine, to be taken every morning half an hour before she got out of bed. She took this for two months with great relief, and then the sickness stopped. She went on all right till full term, and was delivered safely. Child rather large, but nothing else abnormal.

STRANGULATED FEMORAL HERNIA; RESECTION OF THE GUT AT THE END OF ELEVEN DAYS; END-TO-END ANASTOMOSIS; RECOVERY.

By APMORGAN VANCE, M.D.

On January 30, 1893, I was called by her physician to see K. G., aged thirty-three, domestic, who gave the following history:—

Eleven days previously she was taken sick suddenly with vomiting followed by purging. Purging ceased early on the first day; the vomiting continued until seen by the writer.

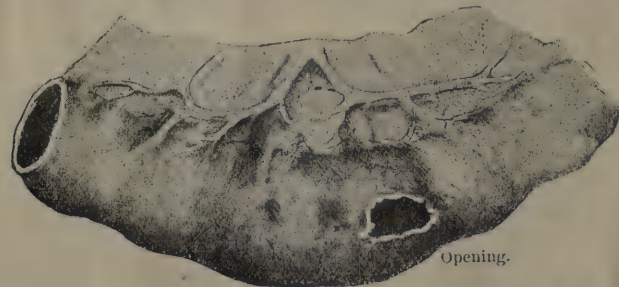


FIG. 1.—Showing sphacelous portion.

It was evident that the extreme modesty of the patient had prevented the physician attending from discovering the cause

of the trouble, which upon closer investigation proved to be a strangulated femoral hernia of the left side.

The patient gave evidence of extreme exhaustion, the pulse being 150; the temperature, according to the physician, subnormal. No history of the hernia antedating the present illness could be obtained, and the patient had never been seriously sick before, though suffering occasionally from "bilious attacks" of short duration.

Nitroglycerine, one one-hundredth of a grain, was administered hypodermically at once, and the patient removed in a rolling chair to the Memorial Infirmary, only a short distance from her residence; and after slight preparation, at 11.30 P.M., the operation for the relief of her condition was begun, Dr. J. W. Guest administering ether, Dr. H. E. Tuley and Dr. C. G. Lucas assisting.

Upon exposure and shaving of the pudendum, the tumour was found to be of about the size of a hen's egg. The sac was exposed and opened, and about half an ounce of very dark-coloured fluid evacuated, and the blackened intestine lifted out of the sac. The sac was much thicker than is ordinarily found in a recent hernia, so it is probable that the hernia had existed without the patient's knowledge.

The very tight constriction was relieved by the hernia knife, and after thorough irrigation with sterilised filtered water, the intestine was carefully drawn out, when one large perforation discharging faecal matter was drawn into view, the intestine being sphacelous in the line of constriction, which included a large portion of the convexity, the mesenteric border not being involved.

This line of slough was fully four inches in length. Resection was immediately determined upon, and an end-to-end anastomosis decided to be best suited to the condition. The assistants each making digital compression (Fig. 2) well on either side of the strangulated portion, nine inches were quickly removed with scissors, the incisions being extended between the vessels down into the mesentery, a silk ligature

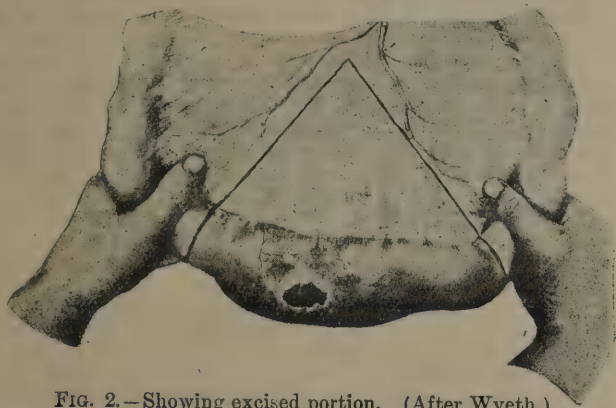


FIG. 2.—Showing excised portion. (After Wyeth.)

being applied and the whole removed. These incisions approached each other so nearly that the part controlled by the ligature was not more than an inch in width.

There was no hæmorrhage, and the suturing was rapidly done as follows:

By a continued fine catgut suture the mesenteric borders were closely approximated; with the same size catgut, which was No. 0, an interrupted suture was passed from the inside through the entire thickness of the intestinal wall, coming out at a corresponding point of the opposing gut to be approximated (Fig. 3).



FIG. 3.—Modification of Wölfer's method. Showing stitches inside.

The part of the intestine above the constriction being greatly dilated and that below being collapsed, made the approximation more difficult, but the result obtained was good.

The first stitch was taken through the mesenteric junctions.

This method of suturing was continued on either side of this point just as far as could be accomplished from the inside (Figs. 4 and 5); the remaining third of the circumference was carefully closed by interrupted Lembert sutures. To make closure doubly sure, a continued Lembert suture was commenced on one side at the apex of the mesenteric angle, and continued from this point around the gut to a corresponding



FIG. 4.—b, b, b, mesenteric border of gut, sutures on inner side; a, a, a, continuous Lembert suture. (After Wyeth.)

point on the other side. By this means there was no fresh surface left uncovered by peritonæum.

During the whole procedure the parts were frequently douched, and every care taken to prevent infection of the cavity.

With some little difficulty the sutured part was returned to the abdomen, the sac being removed high up, and deep approximation sutures applied to the canal. The wound was closed with silkworm gut, with a gauze drain in the lower angle.

The patient's condition at this time was better than when first seen, the pulse being 135 when the operation was commenced, falling to 120 before its completion. The operation was begun two hours after the patient was first seen, and there was certainly a very decided effect from the nitroglycerin, the operation occupying fifty-three minutes.

The fact that the patient had continued so long without nourishment rendered her chances of recovery much less, as an element of exhaustion had to be considered and combated.

The patient was got to bed at 12.30 A.M., and from this time till 6 A.M. she vomited six times a greenish, watery fluid. Pulse ranged between 92 and 140. Morphine, a quarter of a grain with atropine, was given at 1 A.M., and morphine alone at 6 A.M. She slept for a time after two o'clock.

During the day she was restless and hypodermics of morphine were given at noon and at 5 P.M.

The patient received and retained half an ounce of wine and Apollinaris water given every hour during the forenoon, and wine and beef peptonoids in the afternoon.

A rectal tube was introduced at 8 and 11 P.M. and considerable gas passed.



FIG. 5.—After Wyeth.

The pulse gradually increased in frequency from 108 at 1 P.M. to 122 at 5 P.M.

Digitalis was given hypodermically at 9 P.M. and 3 A.M.

The temperature in the evening was 101.6° per rectum.

The patient slept well all the night of the 31st.

February 1st.—During the day the pulse was not above 100; the patient was comfortable except cramping pains in the abdomen. The dressing was changed and hypodermics of morphine were given at 3.30 P.M. Wine and beef peptonoids given every two hours. At seven o'clock on the morning of the third day she was given an enema of water, one pint, which was returned slightly coloured. At 11 A.M. an enema of Epsom salts, glycerine, and water was given, a medium-sized, partly-formed movement resulting. She passed considerable gas and complained of griping pains in the abdomen. She vomited once a large quantity of light-green fluid.

She had four stools during the afternoon and night. Pulse through the day not above 112. Maximum temperature 99.8°. She slept fairly well during the night.

3rd.—She was restless and complained of pains in the

bowels, for which a hypodermic of morphine was given at 5 A.M.

During the day she vomited eight times; only four ounces of peptonised milk were retained. The vomiting was not controlled by sinapisms over the epigastrium or by listerine by the mouth.

The pulse ranged between 112 and 124 during the day. Temperature, 101.4°. Abdomen flat; slight tumefaction over the transverse colon.

During the following day she vomited eleven times, apparently without effort, very little nausea being present, the vomited matter consisting of greenish fluid and at times curdled milk.

She was given aromatic spirits of ammonia, calomel, and morphine. Pulse not over 96. Temperature, 99°.

During the night she vomited nine times, sleeping but little. Maximum pulse, 100; one small, thin stool containing particles of undigested milk.

5th.—During the day she vomited but twice, a good effect seeming to be derived from the administration of oxalate of cerium.



FIG. 6.—Showing completed operation. (After Wyeth.)

Hypodermic injections of whisky were given every three hours, beginning at 7.30 A.M., continued until 11 A.M. on the morning of the seventh day.

6th.—She was unable to take more than one drachm of milk at a time, but vomited only three times.

The wound was dressed at 8.30 A.M. and the stitches removed. A slight discharge of serum at the lower angle of the wound was noted, which continued through the day.

Wine of cocaine was given in teaspoonful doses with half an ounce of beef peptonoids every two hours. The maximum pulse was 118, the rise being caused by the entrance of a stranger into the room.

The patient's general condition at this time was excellent. She continued to improve until the tenth day, when she had four large, thin stools, which were controlled by paregoric and bismuth subnitrate.

The vomiting had ceased, pulse and temperature were normal, the general condition was good. A slight serous discharge continued from the wound.

In every case of emergency of this kind a rapid decision is necessary as to what is best, and this depends entirely upon the condition of the patient. To my mind only one of two procedures is legitimate: If the patient is *in extremis* and plainly unable to withstand a prolonged operation, the production of an artificial anus is the operation; but if, in the estimation of the operator, the condition justifies it, even to straining a point, the patient should have the benefit of the doubt, and a complete operation be performed as in this case.

Either terminal anastomosis by absorbable rings or plates is decidedly less feasible or surgical, as a coeliotomy is made necessary from inability to return the repaired intestine through the small hernial opening.

The risk in coeliotomy is in septicising the cavity, which is rendered *nil* by working entirely through a slightly enlarged hernial opening.

NOTE.—I am indebted to Dr. Henry E. Tuley for the original drawings from which Dr. Macdonald has made those used in the illustrations.

RED IODIDE OF MERCURY, in doses increased from one-twentieth to one-sixth of a grain, and iodide of potassium, in twenty to forty-five grain dose after each meal, continued for two to three months, should be given (says Dr. Seguin, of New York), in addition to aconitine in *tic-douloureux*, even in the absence of syphilitic history.

ON A CASE OF CARDIAC DISEASE COMPLICATED WITH GASTRIC AND HEPATIC SYMPTOMS.

By GEO. SELKIRK JONES, Ph.D., L.S.A.

[An Original Article specially written for MEDICAL REPRINTS.]

S. A., ætat 45, married, no children, a native of India, but resident some years in England, came under my care about eighteen months since for a sudden and pronounced attack of dyspnœa, with subsequent flatulent distension and vomiting of a bilious and dark-coloured changed gastric secretion. The poor woman was, however, destined to suffer many and repeated attacks of this nature ere relief was afforded. Her history revealed much previous suffering; for example, acute rheumatism, Indian ague, and jungle fever, with uterine and ovarian sequelæ. At the time of call I found a well-pronounced pre and systolic murmur and much dyspnœa, pulse quick and intermittent, countenance anxious. There was likewise much hepatic enlargement downwards, with pain, and fear of dissolution.

The urgent symptoms demanded immediate attention, and it was some days before she appeared free from a possible recurrence of them all. The case then presented itself as one of ordinary cardiac disease, complicated with both gastric and hepatic symptoms. She was then placed under proper directions as to diet, &c., with repeated doses of bismuth subnit, tr. digitalis, &c. The case then proceeded favourably for some time, enabling me to try the effect of the new preparation, strontium iodide, for the purpose of counteracting the rheumatic diathesis. This treatment (at first inconvenient) soon became tolerant to her, and appeared to afford much improvement, for I noticed a great diminution of the cardiac murmur, with much less tendency to anasarca and dyspnœa. I regret, however, that, owing to an error in diet, she was obliged to discontinue taking her medicine as above, urgent gastric symptoms subsequently calling for prompt and more suitable treatment. The case occupied some months, and I had no opportunity of continuing the administration of the iodide, which had now to give place to the original treatment with bismuth, but very little advance appeared to be made, in spite of every care with respect to selection of suitable food, &c.

The case was thus reduced to one of atonic dyspepsia and cardiac disease, with the usual complications incidental to hepatic trouble. As to the heart, I was compelled to be satisfied with small doses of tr. digitalis, and the treatment of symptoms (a most unscientific and unsatisfactory proceeding to the medical man, yet one that no doubt redounds much to his credit when viewed from the patient's point of sight). I had now to forbid first one dish and then another, until there appeared in the not very distant future a probable and general fast, for scarcely any kind of food was at this time thoroughly tolerated by her stomach. I was now induced to try the effects of Lactopeptine (Richards), thirty grains after each meal, discontinuing the bismuth for the space of fourteen days in order to give this much-approved remedy a fair trial, with the result that its use became a necessity. Food of every kind, more especially the "peptonic," as meat and milk more particularly, seemed to undergo a more perfect transformation into chyme and chyle, and greater comforts resulting after meals, the repeated attacks of distension, with dyspnœa, became now much less frequent; and when I paid her my last visit and adieu previously to her departure for the London district, the case had assumed a much more hopeful aspect. In this case, I deeply regret these two points of much previous hopeful anticipation unrealised—first, the permanently curative effects of strontium iodide; and, secondly, the case going out of my hands at the very interesting moment when Lactopeptine seemed to afford the essential conditions for complete and effective assimilation.

NOTE.—There can be no doubt as to the prognosis in this case. The cardiac lesion gives but little hope of a lengthened existence for the poor woman; but it is something to know that even under such unfavourable conditions and complications atonic dyspepsia is capable of being successfully combated by Lactopeptine. *Apròpos* of this substance, I see that *free H. Cl.* exists therein. This is a point of much interest to the chemist as well as to the medical man, that to the patient is afforded the full benefit of a good and efficient gastric juice artificially introduced.

INGROWN TOE NAIL; ITS SURGICAL TREATMENT.

By WILLIAM R. HOWARD, M.D.

INGROWN toe nails have long been a source of trouble and annoyance to the surgeon as well as to the patient, and many methods of treatment have been practised with indifferent

success. The causes are many. Trimming the corners of the nail back too close to the fleshy union, hard shoes, shoes too short or too narrow across the toes, too high heels, and congenital soft nails, are the most common causes.

The application of caustic potash to the nail to soften it, and stuffing cotton under the corners, may be successful if done early. Scraping the nail in the centre and lifting the corners with an elastic band has been recommended, and may succeed



FIG. 1.

if done in time. I have used strips of rubber adhesive plaster applied to the flesh at the edge of the nail and passed around beneath the toe diagonally backward, drawing the soft parts away from the nail and treating the corners as above mentioned, with fair success in selected cases. The corners of the nail should be allowed to grow out past the end of the toe, which will always succeed as a remedy, except where the nail is so soft and brittle that it breaks off back to the fleshy union, and this is seldom seen except in the congenital soft nail.

Removal of the entire nail gives only temporary relief, and the trouble returns, usually, tenfold worse than before;



FIG. 2.

for when the nail grows out again it is thick and deformed, often the distal end of the matrix is destroyed, and the nail of sharper incurve than before, both shortening and thickening it.

Dr. Cotting published, a few years ago, a method which has met with favour with most surgeons as the best and most satisfactory cure—that of slicing off the side of the toe from the edge of the nail, removing all of the inflamed part, cutting away the whole side of the toe and treating it antiseptically, allowing the wound to cicatrise over the cut surface, the con-



FIG. 3.

traction of the cicatrix drawing the soft parts away from the nail.

Another method recommended is to remove the nail and destroy the matrix with caustics; this is unwarrantable in all cases that I have ever seen, and will almost always be unsuccessful, resulting in the return of the nail or parts of the nail where the matrix has not been destroyed, in the form of little round hard knots, more troublesome than the ingrown nail, requiring subsequent operations which must be very painful.

A method which to me is new, and which has only been practised by myself so far as I know, is simple, rational, and in more than a score of cases has been successful, giving satisfaction in every way. Fig. 1 shows the condition of the toe with ingrown nail, also the cut made for the operation. Commencing about three sixteenths of an inch from the edge of the nail, passing the knife directly toward the bone, not going deep enough to wound the periosteum, make the cut from the centre in front, horizontal to the plantar surface,



FIG. 4.

around the back to a line a little beyond the proximal end of the nail; next begin at the same place as before, pass the knife in a semicircular manner, ending with the proximal end of the first cut, removing an elliptical wedge-shaped section by bringing the cuts together at their deepest angle. A piece three eighths of an inch in width is often sufficient to draw the soft parts away from the nail when closed. Bring the edges together with deep silk sutures, as in Fig. 2, dress antiseptically, and immediate union will take place. On the fourth day the sutures may be removed and the wound dressed as in any other case. In from a week to ten days a shoe may be worn with perfect comfort.

The operation is rendered nearly bloodless by placing a small rubber band around the toe, which is allowed to remain till



FIG. 5.

the wound is closed. The time taken is less than ten minutes after the patient is thoroughly anaesthetised. It may be asked, why not use cocaine or some local anaesthetic? In reply, I have noticed that in all cases of plastic surgery where these local anaesthetics have been used they have operated against perfect immediate union, upon which the success of the operation so often depends.

This operation may be varied to suit the case; for instance, where both corners are ingrown, or where the nail has been removed and is short and sharply incurved, and allows the end of the toe to rise all around above the nail, as in Fig. 3,



FIG. 6.

the cut should be made around the entire end of the toe (Fig. 4), and a piece sufficiently large removed to bring the nail above the surrounding soft parts (Fig. 5).

Often the second toe overrides the deformed great toe (Fig. 3, dotted lines); in such cases we usually find that the deformity consists in a bag, so to speak, containing fragments of hypertrophied nail which keeps up the irritation, maintaining an abscess, often encysted, causing hypertrophy of the soft parts. These must be carefully and certainly removed.

In all cases endeavour to preserve the matrix, especially along the edges and around the distal end of the nail.

There is naturally a great difference in the degrees of firmness of toe nails—some are soft and brittle and will not bear any bending without breaking, while others will bear any amount of manipulation safely. Where we have trouble with these soft nails, the corners usually break off and the soft parts are wont to overlap and cause inflammation around the edges (Fig. 6). When tight shoes with high heels are worn, there is very little that can be done to benefit them. An operation, which has for its object the removal of the greater part of the toe, making the cut entirely round the end, extending it back nearly to the distal joint, will relieve these cases, if followed by wearing a shoe with broad toe and low flat heel. The application of one part of paraffin and two parts of tallow will tend to toughen the nail and to hold the two soft parts away from the nail. Many cases may be relieved by this application alone, if properly applied at the onset of the trouble.

A CASE OF NASAL POLYPUS PROJECTING INTO THE NASO-PHARYNX.—WITH SPECIMENS.

By SAMUEL JOHNSTON, M.D., Baltimore.

[Read before the American Laryngological Association at its Fifteenth Annual Congress.]

THE patient from whom these specimens were removed was sixty years of age.

She consulted me with a history, briefly, of nasal obstruction, difficulty in swallowing, and impaired voice production. For many years previous to the onset of these symptoms she had suffered from catarrh, but had never had epistaxis.

Several reflexes were present, notably asthma, and her distress was indescribable.

Upon anterior rhinoscopy, the right nostril was seen to be occluded at its posterior opening, the left one being pervious.

On inspecting the mouth, a tumour of unusual size, grayish in colour, non-vascular, and firm to the touch, was observed



FIG. 1.—Side view of the polypus.

to protrude between the border of the soft palate and the post-pharyngeal ball.

When vocalisation was attempted, the growth disappeared into the naso-pharynx, pushing forward the velum.

After removal with the snare, the growth was found to be of about the size of a pullet's egg, slightly flattened, with a smaller one adjoining, and was seen, upon examination, to have had its attachment by a narrow pedicle to the inferior turbinated bone.

A year later the patient returned with a train of symptoms similar to those presented on the first occasion, though not so pronounced. Examination revealed a mucous polypus hanging freely over the velum, almost touching the base of the

tongue. The gross appearances of this growth were quite in contrast to those of the first one.



FIG. 2.—Front view

The tumour measured two inches in length and three quarters of an inch at its thickest part.

Polypi having their origin in the nasal passages and grow-



FIG. 3.—Recurrent growth.

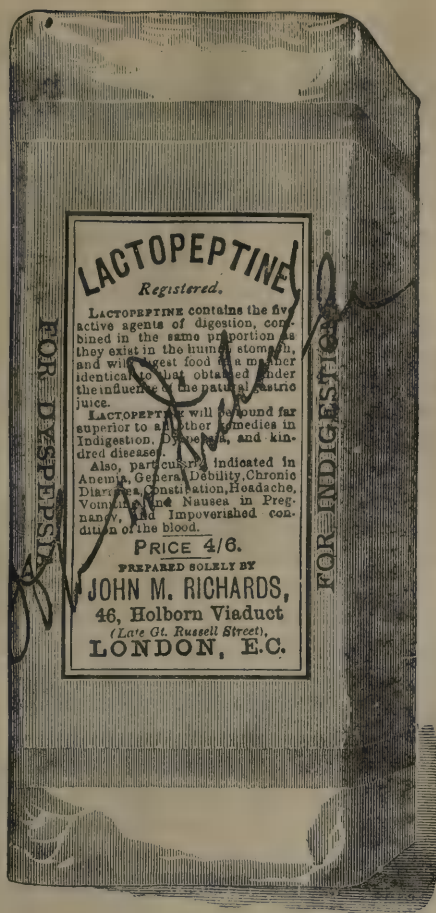
ing posteriorly to the size of these specimens are uncommon in my experience, and I have thought them not unworthy of presenting to the Association.

A WORD OF CAUTION.

THE extensive use and approval of LACTOPEPTINE by the medical profession, by whose recommendation and for whose convenience it has been so long sold, has had the effect of making this proprietary drug a regular part of the stock in trade of every dispensing chemist.

It has now, however, become necessary to warn the profession against a widespread attempt to procure the substitution of imitations for the true LACTOPEPTINE, a definite product having latterly been openly recommended even to medical men as a substitute for LACTOPEPTINE.

While, so far as medical men are themselves concerned, there can be but little fear of this artifice succeeding, it may be well to point out the danger of patients, when directed (as they often are by physicians) to obtain LACTOPEPTINE for themselves, being supplied with some dubious new mixture,



1-OZ. WRAPPED.

which cannot, of course, command the confidence of the prescriber in the same way as the true LACTOPEPTINE, which has been prepared under the constant and vigilant scrutiny of the medical profession for some twenty years.



1-OZ. UNWRAPPED.

It is, therefore, respectfully suggested that where LACTOPEPTINE is ordered to be obtained by patients, the latter may be directed to purchase it in the original package, in its pink and white wrapper as here shown, with the fac-simile signature of the manufacturer across the front.

LACTOPEPTINE is frequently presented by medical men in combination with other drugs. To ensure the authentic preparation being dispensed, it is respectfully suggested that the name "RICHARDS" be added in brackets to the word "LACTOPEPTINE," to guard against mistake or wilful substitution of cheaper imitations. It is needless to say that no substitute, whatever its composition, correctly fulfils the requirements of a medical prescription of LACTOPEPTINE, and that such substitution is a wilful fraud alike on the prescriber, the patient, and the manufacturer of the true product.



4-OZ. DISPENSING BOTTLE UNWRAPPED.

Medical practitioners, who dispense their own medicines, are specially warned against touting circulars offering a cheap preparation as a substitute for LACTOPEPTINE. LACTOPEPTINE is sold to the profession unstamped, for dispensing, in 1-oz., 4-oz., and 8-oz. bottles only—never in bulk—at 3s. 3d., 10s. 6d., and 20s. 6d. respectively. The exact appearance of the 4-oz. bottle, after removal of the outer blue paper, is here shown.

LACTOPEPTINE is a progressive and philosophical product. The activity of the digestive ferments of which it is composed is unequalled, and has stood the continuous tests of twenty years, both in the laboratory and in the clinic. It is worth the while of prescribers and medical men generally to take care that their rights are not infringed and their patients not defrauded by the substitution of specious imitations. Nothing that is useless is really cheap, and it is a gross invasion of the physician's right if the drug he prescribes is set aside in favour of something that someone else presumes to think equivalent, on the evidence of touting circulars offering the imitation for sale.

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

SEPTEMBER 15th, 1893.

IN another column, the attention of medical men is drawn to a recent interference with the rights of the profession, which appears to merit a more pointed protest in this place. We allude to the substitution, in dispensing prescriptions, of cheap imitations for the drugs desiderated by the prescriber.

A medical man may be assumed to be the best judge of his patients' requirements; and the selection of a definite and perfectly well known product by a prescriber leaves

the pharmacist no legitimate option to dispense another product which the latter may happen to consider applicable. We do not believe that any other opinion is held by the preponderating majority of dispensing chemists; but our comment has been drawn forth by a case brought to our notice by an eminent medical man, in which, desiring the well-known drug LACTOPEPTINE, he found himself supplied with a cheap mixture described by a rather ignorant name, and calmly recommended as a substitute widely accepted—though by whom so accepted this interesting document unhappily failed to state.

A prescriber who orders LACTOPEPTINE is entitled to have LACTOPEPTINE dispensed to his patient. It is a product which, by its long standing and progressive excellence, has earned the approbation and confidence of the profession, as no cheap imitation can do. It is hardly necessary to remind readers of this publication that every facility has, for the past twenty years, been afforded to medical men to acquaint themselves with, and test the claims of, this drug at first hand. It is a continuous offer of the manufacturers to supply a bottle of the drug free of all charge to any practitioner desirous of acquainting himself, either in the laboratory or clinically, with its qualities. This offer is still open. The result of its acceptance has been a series of emphatic and unanimous endorsements of its merits extending over a long period of years by the only class of writers entitled to be heard in such a connection—namely, the most enlightened scientific and expert community in the world, the medical profession of Great Britain and Ireland, of whose opinions an entirely new selection appears in this issue. Can any cheap so-called alternative, however loudly touted, exhibit such evidence?

TO MEDICAL AUTHORS.

THE Proprietor of this publication is desirous of obtaining for publication in MEDICAL REPRINTS original essays and clinical notes on subjects full particulars of which will be obtained on application by letter to

The Editor of MEDICAL REPRINTS,

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NOTICE.

THE HUNTER CENTENARY.

IN commemoration of the hundredth anniversary of the death of John Hunter, who died while speaking at a Board Meeting in St. George's Hospital, on October 16th, 1793, MEDICAL REPRINTS for next month (published October 16th) will contain a specially written article illustrated by a number of engravings of places and objects of interest in connection with the Hunter Centenary, and by a photographic engraving (made by the kind permission of the Royal College of Surgeons) of the bust of Hunter and the oil painting by Sir Joshua Reynolds, now in the College House in Lincoln's Inn Fields. The same issue will contain (as usual) a number of illustrated articles and reprints on technical subjects and other features of interest.

LACTOPEPTINE.

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NEWS AND NOTES.

A CORRESPONDENT writes, in reference to a recently recorded case of post-mortem birth: "Several years ago I saw a similar case. The body of a woman had been brought to the dead-house in a coffin, where it was left awaiting transportation to the city cemetery for interment. This was during a very hot spell in the summer. On examination of the body, some time after it had been received, it was noticed that a child had been expelled from it. The funis was still attached, unbroken, and the placenta had not left the mother's body. The cause of the expulsion was very evident. The gases of decomposition had distended the abdomen enormously, and without doubt exerted sufficient pressure to drive out the child. It lay between the woman's thighs, quite in the same position that it would have assumed if the birth had taken place in the ordinary way. These cases seem to me to possess a medico-legal interest. It is within the range of probability that a child delivered in this way, and found in a grave, with no record of its interment there, might become a very mysterious affair, and perhaps lead to a suspicion of crime. While, in the two cases now reported, the presence of a second body is explainable, it is quite possible that under some other circumstances it would not be so easily accounted for."

DR. C. F. CREHORE offers, in the *Boston Medical and Surgical Journal*, a suggestion accounting for the present prevalence of appendicitis. Looking beyond food and clothing as etiological factors, he finds in one particular a condition of recent origin which may possibly explain, in some degree, the frequency of the disease. This (he says) is "the comparatively recent and very general introduction of methods of physical culture and the resultant growth of athletic sports. Calisthenics, as generally taught, appear harmless enough; but many of the postures involved cause a good deal of abdominal pressure. It goes without saying that where an overloaded ascending colon is subjected to such pressure, a portion of the fluid matter entering from the ileum might be forced downward into the appendix and be the cause of serious disturbance. The danger from such a contingency would naturally be increased in the more violent gymnastics and the rougher athletic games—as baseball or football, rowing, polo, and the like. The position of the modern bicyclist when riding seems very favourable to an injury of that description." Dr. Crehore's suggestion is no doubt an ingenious one, but it omits to make allowance for a logical factor which, in our opinion, is vital to the question, namely, the greater accuracy of recent diagnostic methods, which detect and classify many cases of appendicitis formerly attributed to other causes. This probably contributes more literally than any athletic sport to the records.

DR. EDWARD BERDOE, author of "Browning Cyclopædia," has employed his pen in a task eminently interesting to the profession of which he is a member in his last work, "The Origin and Growth of the Healing Art" (London, Swan Sonnenschein & Co., 1893). The history of medicine is a subject seldom dealt with in any exhaustive manner, though it is one whose fascination is abundantly marked by the interest excited by such of the periodical orations as deal in it, and by the excellent monographs which have appeared in *The Lancet* and other contemporaries. "A Chronology of Medicine," by Mr. John Morgan Richards (London, Baillière, Tindall, & Cox,



DR. CHARCOT.

1880), had a widespread circulation, and is still frequently referred to. Dr. Berdoe has set himself the task of a more exhaustive scrutiny of the historical and ethnological aspects of the medical sciences, and has produced a highly interesting and readable work of literature. To properly appreciate the history and derivations of medicine it is needful to be something of a folk-lorist as well as a man of science. The medicine of the ancients was, and that of savage nations to this day remains, rather a matter of conjecture, superstition, and (we had almost said) poetical license, than of observation. The physician was guided rather by a vague idea of what ought to happen, than by observation of what actually *did* happen in given case. If a man had the gout in the right foot he must eat the right foot of a frog, and, conversely, if in the left foot, the left foot of that unfortunate amphibian. The selection of a frog as the victim of this mediæval prescription is obscure; but there is a delicious unreasonableness about the remaining detail. However, it is hardly for the nineteenth century to cry out. Only a few years ago, as many readers will remember, a wild flower was discovered in America having a stamen which, when dissected, presented a marked resemblance to the male organ of generation. It occurred to some wiseacre (the idea having been suggested by this by no means rare physical formation) that the plant ought to yield an extract curative in disorders of the paternal function, and the lay community seized on the idea with so much avidity, and (as usual with lay medicines) reported such extraordinary results, that a section of the medical body in the Southern States of America temporarily lost its head and plunged into a wholesale series of abortive experiments with the flower in question. This is a true revival of mediæval medicine. The list of animal products daintily culled as articles of pharmacy by our forefathers is lengthy and disgusting; but are animal extracts entirely unknown to the medical science of to-day? The truth is, however, that modern medicine is not an evolution from the therapeutics—if we may so designate them—of the past, but a new growth, proceeding on original principles. They are, it is true, but the principles of the *Novum Organum*, the "new instrument" of Baconian philosophy; but the centuries following Bacon became only by very slow degrees sterile in medical curiosities of the ancient-world type. Dr. Berdoe carries the subject down to the latest date, dealing with the development of the germ theories and the progress of the new surgery. He has made the profession and (since the book is essentially a popular one) the public, his debtors, by an admirable piece of work.

It is well known in rural districts that bee-keepers and other persons much exposed to the stings of these insects acquire a convenient immunity from the usually disagreeable effects thereof. Some two years ago an Austrian physician advanced the remarkable theory that persons who have been stung at all by bees enjoy the same, or a partial, immunity for varying periods, and that, moreover, the virus of the bee-sting is an infallible remedy for acute rheumatism. The latter part of the theory, according to *The Mediterranean Naturalist*, has received unquestionable confirmation from a custom of the country people in Malta. Bees are plentiful in the island, and bee-stings are in such repute as a cure for rheumatism that resort to this primitive method of inoculation has been a common practice in severe cases for generations, the results having been most satisfactory to the patients—when the stings had got better,

A BOY died in New York during June, 1892, while under the influence of chloroform, and although a coroner's special jury of medical men (permitted by the laws of the State of New York) exonerated the physicians present at the operation from all blame, the parents of the child now assert that the anæsthetic was carelessly administered, and have sued the medical attendants for damages. The boy was four years of age, and the damages claimed are £1,000! Actions for malpractice, happily rare in this country, are rather common in America, though it is fair to say that they do not often succeed.

DOM SANTON, a Benedictine monk, who has had a medical training, has been commissioned by the French Government to make a special study of leprosy in Scandinavia, Finland, Turkey, Asia Minor, Greece, and Egypt. When his investigations are complete, he will return to Paris, where he will lay his results before M. Pasteur, with a view to the possible discovery of a remedy for the disease.

RECENT reports from Mexico state that a remedy for typhus fever has been found in jicama (*Dulichos tuberosus*), a plant cultivated to some extent in the tropical regions of America. So many recoveries from the disease under domestic treatment by this plant have been reported, and so great is the popular interest in its alleged virtues, that the Mexican Medical Institute has now appointed a special commission to study the remedy, which is to be subjected to microscopic examination and chemical analysis, and with which experiments are to be made upon typhus patients. Jicama (pronounced Hee'camah) is a valerianic plant, indigenous it is said to New Holland, which is cultivated in Mexico and the West Indies on account of its popular reputation as a valuable remedy in diseases of the chest, and in scabies, "the connection of which with the plot one sees," to quote Calverley's invaluable line.

A DAILY paper published not long ago a despatch from Mexico in which it was stated that among the large shipments of bones from Mexico to the United States recently made for fertilising and sugar-refining purposes, were ten car loads of human bones said to have been obtained from ancient mounds in Southern Mexico, but more probably gathered from various old and abandoned cemeteries. As these bones are fragments from different skeletons, fifty thousand individuals are represented in the lot. The despatch does not say whether this particular shipment was designed for use as fertilising material or for refining sugar.

IN a paper published in a recent volume of the *Archives des Sciences Biologiques*, Dr. Ouskoff, speaking of certain facts observed at the post-mortem table, says, naively enough: "Thanks to the presence in our hospitals of so distinguished a clinician as the lamented S. P. Botkine, I have generally been able to continue at the autopsy the study of the complex symptoms observed during life." It must (remarks a contemporary) be a satisfaction to a distinguished clinician to be of assistance to his pathological colleague, even if he cannot save his patients.

AMERICAN OPINION.

ON CARBUNCLE AND ITS TREATMENT.

By P. C. BARKER, M.D.

ONE of the striking characteristics of medical magazine contributions of the present day is the tendency to elaborate—to pad. The result is that many readers have gradually fallen into the habit of turning over the leaves of their journals, noting a sentence, or an idea here and there, without perhaps, really reading a single article. The writer desires to call the attention of the readers of this Journal to what he believes to be an entirely new treatment of carbuncle; and, with the above criticism in view, he will, without

discussing the etiology of the disease, or the process of reasoning that led to the adoption of the treatment—proceed at once to describe it in detail. Take a large hypodermic syringe, fitted with a small needle. Fill the syringe with a 1-to-500 solution of mercuric chloride and insert the needle into one of the openings of the carbuncle as far as it will readily go. Inject the solution so as to thoroughly wash out the little cavity immediately beneath the opening. Then thrust the needle into the surrounding induration from the little cavity and force a little of the solution into these tissues. Of course not much can be thus introduced. Repeat this proceeding until every opening or impending opening has been washed out, and its corresponding periphery has been thus injected. With the exception of the injection into the infiltration this is entirely a painless proceeding, and the patient experiences a decided sense of relief after even the first cleansing. Dress the carbuncle with some weak antiseptic ointment as often as may be necessary, and repeat the injections (reduced to 1 to 1,000) daily until the slough has separated. No matter whether there are two or three small openings, or a dozen, when treatment is commenced—whether the induration is an inch or two or three inches in diameter—there will be no extension of the resulting slough after the first injection, if it be thoroughly done. If this treatment is commenced at an early period, while there are only two or three openings and but very little surrounding induration, the carbuncle will be entirely healed in a very few days. The writer has repeatedly employed this treatment, and success has invariably resulted.

For boils, carbolic acid and glycerine yield equally good results. Cases in illustration might be given, but, as they would add nothing to the practical value of the contribution, they are withheld.



SIR CHARLES CAMERON, BART., M.P.

[From a Photograph by Messrs. Elliott & Fry.]

A CASE OF NASAL HYDRORRHOEA.

By GEORGE F. KEIPER, A.M., M.D.,
Eye and Ear Surgeon to St. Elizabeth Hospital, Lafayette.

F. B., an architect, consulted me on May 7, 1892, on account of a constant and profuse discharge from his nose which, on account of his occupation, was most annoying. Nothing in his previous history could account for it.

The nares, upon examination, presented all the characteristics of hypertrophic rhinitis. Treatment was immediately instituted for the reduction of the hypertrophied tissue, but after

six months' faithful treatment the discharge continued unabated. All the remedies ever suggested for relief of similar cases failed here, cocaine included.

After considerable thought upon my patient's condition, I ordered the following:

R Atropine sulph. gr. ij;
Aque dest. 3 j.

M. Sig.: Spray each nostril morning, noon, and night.

Within two days the discharge markedly lessened, and since then has been in normal quantity only.

The patient suffered some inconvenience at first on account of getting some of the solution into his eyes, but by due caution he has had no trouble since, though he still uses the atomiser.

These cases are rare, and for that reason, I report. The treatment as laid down by our authorities is confessedly discouraging, and this case is reported because it has brought in my case atropine into a new relation.

CAFFEINE acts directly on the nervous system in vasomotor heart troubles, and in moderate dose stimulates the heart muscle. Acting upon the cardiac innervation, it provokes dilatation of the vessels. With this drug muscular and nervous troubles of the heart can be combated which previously resisted all treatment. Beginning with daily dose of a quarter to half a gramme, it can be gradually increased until two or three grams are taken in the twenty-four hours. It is best given subcutaneously, combined with an equal quantity of benzoate of soda.—Ferrara.



OUR ILLUSTRATIONS.

THE CHILDREN'S HOSPITAL,
GREAT ORMOND STREET, LONDON.

THE new wing at the Children's Hospital in Great Ormond Street was opened several weeks ago by the Prince and Princess of Wales (with whom were the Duke of Fife, the president of the hospital, the Duchess of Fife, and the Princesses Victoria and Maud of

Wales), and is now in, or ready for, actual use.

It formed, as is well known, a part of the original plan promulgated in 1872, but was eliminated, *pro tem.*, for want of funds.

The addition contains: (1) Four wards, providing sixty-seven additional cots; (2) extra accommodation for out-patients; (3) additional nurses' dormitories; (4) servants'



dormitories; (5) lady superintendent's apartments; (6) committee room and secretary's office. The building, furnishing, and fitting up, including several important improvements in the central block, entailed an expenditure of £40,000. The cost of maintaining the hospitals as now enlarged to 192 beds, is estimated at £15,000, and the committee depends on the increased support from the public for the extra £3,000 a year.

The foundation stones of the central block were laid, on July 11th, 1872, by the Prince and Princess of Wales (always enthusiastic patrons of this noble charity). The addition then inaugurated rendered possible an increase of the number of beds to 127, which number, by the addition of the new wing, is now increased (as we have seen) to 192. Since the foundation of the hospital in 1852, with a poor twenty beds (an event in which Dickens took the greatest possible interest, giving a special reading on behalf of the funds) no less than 500,000 children have been treated at the hospital.

How stupendous must be the amount of relieved

suffering represented by this figure!

During 1892 there were 1,281 in-patients at Great Ormond Street—294 of them under two years of age. Two hundred and eighty in-patients were received at Cromwell House, Highgate, the convalescent branch of the hospital, and the out-patients numbered 21,045. The necessity of increasing the work and scope of the hospital in response to the urgent and growing demand for admission will be met to a certain extent by the new wing, and the committee confidently appeals to the public for funds to carry on their good work, donations towards which, to the extent of over £3,500, have been received.



THE CHILDREN'S HOSPITAL—NEW WING.

The hospital has been happy in its friends. Royalty, as already shown, has always smiled upon it. The Duke and Duchess of Fife, presidents of the institution, fulfil not merely honorary office. Like the Princess of Wales, they have taken pains on numerous occasions to become personally acquainted with the poor little inmates. The Princess of Wales, whose portrait, with her tiny grand-daughter, hangs in the Alexandra Ward over the "Lady Alexandra Duff" cot, named in honour of the Royal infant, had delighted on occasions to charter the services of the Duke of Fife, who is described as obediently conveying her Royal Highness, laden with toys of all sorts and descriptions. The Princess Victoria and Maud of Wales, on the occasion of the opening of the new wing, were with difficulty persuaded to leave the delighted children in favour of the official ceremony of the day.

It is among the privileges of royalty to give much pleasure with but little sacrifice in time and effort. But there are few sadder sights in London than the wards of this Hospital for Sick Children, and no one who loves and cares for children can visit them unmoved. Yet it is only by a personal inspection that any adequate idea can be gained of the splendid work herein carried on, and the great necessity of keeping such a charity free from pecuniary cares.

A GALLERY OF MEDICAL PORTRAITS.—XXI.

THE LATE DR. CHARCOT.

By the death, which occurred very suddenly last month, of Dr. Charcot, the medical profession in France loses one of its brightest lights, and medical science one of its most energetic and intelligent adepts. By his painstaking and



persistent researches in a department of pathology previously enveloped in obscurity, he succeeded in throwing a flood of light on morbid processes of an exceedingly recondite and complicated kind. In fact, the whole modern literature of nervous and psychical disease is practically based on Charcot's work, and there is scarcely a mental disease or a symptom in reference to which he has not added to our knowledge. The famous clinic at the Salpêtrière Hospital proved, under his guidance, to be the very nursery of psychology in all its ramifications.



Sneered at and derided in his younger days, he succeeded in frustrating all opposition, and he made his name a household word wherever medicine is studied and practised. The principles of close and exact observation, both at the bedside and in the post-mortem room, will survive him, and will enable his successors to take up the torch and to throw further light on



processes still obscure. Generation after generation of earnest students have sat at his feet, anxiously recording the words of wisdom which fell from his lips. From every land men came to learn from the master the secret of elucidating the mysterious, and of differentiating the functional from the organic. His name will be remembered in medicine, along with those of Bright, Lister, and Pasteur, in centuries to come, when individualities have been effaced and achievements only remain.

SIR CHARLES CAMERON, BART., M.P.,

is one of our medical legislators. He was born in 1841, and educated successively at Madras College, St. Andrew's, and Trinity College, Dublin, where he graduated as A.M. and M.D. in 1865, taking the degree of LL.D. in 1870. He entered Parliament in 1874, and at present represents the College Division of Glasgow in the House of Commons. In addition to his Parliamentary duties (by no means light, since he is in charge of the bill for the Disestablishment of the Scottish Church recently adopted by the Government), Sir Charles Cameron finds time to edit a great newspaper, *The North British Daily Mail*, and has occasionally contributed to

professional and current literature. He had a brilliant collegiate career, having been a First Gold Medallist and Senior Moderator in Experimental and Natural Science, and a Gold Medallist also of the Royal Dublin Pathological Society.

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

SORE THROAT.—The following is recommended in the treatment of sore throat:—

℞ Cocainæ hydrochlorat	...	...	...	grs. viij.
Acid. carbolic	...	...	...	3 i.
Glycerinæ	...	...	...	℥ iv.
Aquæ rosæ q. s., ad.	...	...	...	℥ xii.

M. Sig.: To be diluted with an equal quantity of water, and used alternately as a spray and gargle.

Medical Progress.

POMADE FOR PSORIASIS OF SCALP.—Besnier gives the following:—

℞ Potash soap	...	...	...	20 gm.
Vaselin	...	...	...	20 gm.
Ichthyol	...	...	...	2 gm.
Salicylic acid	...	...	...	1 gm.
Pyrogallic acid	...	...	...	1 gm.

Mix and make a pomade, which is to be applied every day to the plaques of psoriasis. If much irritation is created, suspend the application temporarily.

IN NERVOUS IRRITATION, accompanied with diarrhoeal discharges incidental to teething, in persistent and severe forms, we prescribe:

℞ Camphor monobrom	...	...	...	gr. xii.
Salol	...	...	...	gr. ix. to xii.
Hydrarg. eum creta	...	...	...	gr. xii.
Lactopeptine	...	...	...	gr. xii. to xvii.

Triturate and div. in cht. xii.

Liq.—One powder every four hours.

As a simple corrector of the digestive organs there is nothing that has so frequently answered our purpose as Lactopeptine.—*Medical Summary.*

ORIGINAL CORRESPONDENCE.

DEAR SIR,—I have frequently, for years past, prescribed Lactopeptine to my patients suffering from the various forms of dyspepsia, and have generally found excellent results from the administration of same.—Faithfully yours,

A. F. WILLIAMS, L.F.P.S.G., L.M., L.S.A.

Laurel House, Guilsborough, Northampton,
August 24th, 1893.

DEAR SIR,—I frequently prescribe your Lactopeptine and have a high opinion of its value in all forms of indigestion. I have found it particularly valuable in cases of gastric catarrh, both during the acute stage and during convalescence. It generally acts very well when given alone, but when there is much irritability of the stomach, I think it is best given in mixture with bismuth and hydrochloric acid.—Yours truly,

P. STEWART, M.B. and C.M.

Langley Moor, Durham,
August 19th, 1893.

DEAR SIR,—I have been in the habit of using Lactopeptine in my practice for a considerable time as I find it extremely useful in the treatment of that common disorder dyspepsia. What with patients who have such a defective set of teeth they cannot masticate their food properly, others who have an atonic condition of their stomach, others who suffer from flatulence consequent upon slow digestion and fermentative changes; a remedy like Lactopeptine that is so great a help to digestion, that is palatable, and will keep—unlike so many pepsin preparations—is simply invaluable.—I am, yours truly,

A. E. HUBAND, L.R.C.P., L.R.C.S., L.F.P.S.

Sutton-Bonington, Loughborough,
August 18th, 1893.

DEAR SIR,—In reply to yours *re* Lactopeptine, I have seen very good results from the administration of the remedy in



various kinds of dyspepsia both in adults and infants, and I still continue to use it freely.—Yours faithfully,

E. COCKEY, M.R.C.S., L.S.A.

West Lodge, Frome,
August 25th, 1893.

SIR,—I have found Lactopeptine to be very useful and beneficial in atonic dyspepsia, taken with or after food.

J. G. CREASY, M.R.C.S., L.S.A.

West House, Wrotham, Kent,
August 28th, 1893.

DEAR SIR,—My experience in the use of Lactopeptine is most satisfactory, and I frequently recommend it in appropriate cases, viz., such as it professes to benefit, and very rarely without justifying such profession.—Yours faithfully,

HENRY DIXON, M.R.C.S., L.S.A.

Watlington, Oxford,
August 16th, 1893.

DEAR SIR,—In reply to your inquiries about my experience of Lactopeptine, I am pleased to say that I have found it a very useful remedy, and one I should be sorry to do without. In acute attacks of atonic dyspepsia I have seldom found it to fail in giving immediate relief.—Yours faithfully,

C. R. LEADER, M.B., R.U.I., M.Ch., B.A.O.

Worthen, Salop,
August 16th, 1893.

SIR,—I have used a considerable amount of Lactopeptine in my practice, and have generally found it of much value in cases of dyspepsia, &c.—Yours truly,

W. F. FULLER, L.R.C.S.I., L.A.H., L.M.

Balbriggan, Co. Dublin,
16th August, 1893.

DEAR SIR,—I have prescribed your Lactopeptine for some years, and have found it very beneficial, especially in cases of chronic indigestion.—Yours faithfully,

T. W. KYLE, M.D., Q.U.I., L.M., D.P.H., R.C.S.I.

Measham, Atherstone,
16th August, 1893.

DEAR SIR,—I have much pleasure in informing you that it is now several years since I first used Lactopeptine, and during these years it has proved so useful in cases of dyspepsia, particularly chronic, often curing the latter when everything else has failed, that I cannot consider my drug-room completely furnished without it. In proof of which I shall feel obliged if you will send me on another bottle, for which I enclose 10s. 6d.—Yours &c.,

R. H. VEREKER, L.R.C.P.I., L.M., L.R.C.S.I.,

Eastleigh, Curry Rivel, Taunton,
August 23rd, 1893.

DEAR SIR,—I have great pleasure in stating that Lactopeptine is a splendid combination of drugs, and that in atonic dyspepsia acts marvellously combined with tr. nucis vom. and inf. gent. co.—Yours truly,

W. G. SCARTH, L.R.C.P., L.R.C.S., L.F.P.S.,

Woodhouse Hall, Leeds,
16th August, 1893.

DEAR SIR,—I have had occasion to recommend your Lactopeptine to my patients for a number of years, and have invariably found it very useful in cases of severe dyspepsia (chronic) and also in the diseases of children where there is a want of assimilating power.—I am, yours truly,

R. MASON, M.R.C.S., L.S.A.

29, Cavendish Street, Ramsgate,
16th August, 1893.

DEAR SIR,—Ever since using the sample of Lactopeptine which you sent me I am never without it. I have powders of ten grains always ready dispensed, and put up in packets of six. Out of some fifty or sixty cases it has never failed me yet.

L. F. DODS, L.S.A.

Joydene, Fenny-Shelford, Bucks,
August 16th, 1890.

DEAR SIR,—I am very pleased with the result in the cases in which I have used Lactopeptine.—Yours truly,

J. T. BROWN, Esq., M.B., C.M.

Strathwey, Tintern, Mon.,
August 16th, 1893.

DEAR SIR,—For many years I have administered Lactopeptine in various derangements of the stomach, and always with very beneficial results. I consider it the *sine quâ non* of the dyspeptic.

W. RODERICK, L.S.A.

Oswestry, Salop.

SIR,—I have employed Lactopeptine very extensively during the past year or two, and have found it especially useful in the treatment of atonic dyspepsia; also in those cases of malnutrition in young children, so commonly designated marasmus. Its administration during convalescence from the specific fevers, such as enteric, influenza, &c., is particularly indicated, as in all other conditions of impaired indigestion.

E. A. PIGGOTT, L.R.C.P., L.R.C.S., L.M., L.S.A.

Brookside, Clare, Suffolk,
August, 1893.

DEAR SIR,—I have found Lactopeptine beneficial in the majority of cases in which I have tried it, especially in acute dyspepsia, with vomiting.—Yours truly,

J. W. UNSWORTH, M.B.

Blackrod, Lancs.,
August 16th, 1893.

DEAR SIR,—I find your Lactopeptine without equal in treating cases of indigestion, and rarely have a case that is not improved by it. In infantile diarrhoea it is a drug of great value.—Yours faithfully,

W. HALL, L.R.C.P., L.R.C.S., L.F.P.S. and L.M., L.S.A.
Victoria Villas, Tubbs Road, Harlesden, N.W.,

14th August, 1893.

DEAR SIR,—Your Lactopeptine is invaluable for dyspepsia and catarrh of the stomach, and I have much pleasure in writing to tell you so. It has been of the greatest benefit to myself personally, and I cannot do without a supply of it.—Yours &c.,

R. MAC LELLAND, M.B., C.M.

Wigton, N.B.,
August 17th, 1893.

DEAR SIR,—I have much pleasure in stating that I have the highest opinion of your Lactopeptine in cases of dyspepsia. I have used it with success in eczema arising from non-assimilation of food.—Yours faithfully,

I. NEWTON, M.R.C.S.

Roundham Head, Paignton,
August 16th, 1893.

DEAR SIR,—I often prescribe Lactopeptine and am pleased to state that from my experience I believe it to be a very valuable preparation, especially in cases where there is an atonic condition of the stomach.

ALLAN MILL, L.R.C.P., L.R.C.S., L.F.P.S.

Bushmills, Co. Antrim,
August 29th, 1893.

DEAR SIR,—I entertain a high opinion of the Lactopeptine as a digestive. I have no large experience of it; but wherever I have given the preparation the result has been eminently successful. One patient, formerly a martyr to flatulence after every meal, especially after dinner, is now comparatively free from it. She has taken it with each meal.

CHARLES R. FRANCIS,

M.B. London, M.R.C.P. London, M.R.C.S. Eng., &c.
15, Spencer Park, Wandsworth Common, S.W.,
August 16th, 1893.

SIR,—In answer to your letter respecting Lactopeptine I may say that I have been prescribing it now for many years in cases of dyspepsia of various kinds, and have over and over again proved it to be a very valuable remedy.—Yours truly,

H. H. THOMAS, L.R.C.P. London, M.R.C.S. Eng., &c.

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I have found it very beneficial in many cases of dyspepsia, and in relieving the morning sickness of pregnancy invaluable.

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MEDICAL REPRINTS

Home, Foreign, and Colonial: with Original Essays.

VOL. IV.]

LONDON: OCTOBER 16TH, 1893.

[No. 45.

October 16th, 1793-1893. JOHN HUNTER CENTENARY NUMBER. See Pages 133 to 135.

DR. KOCH ON THE DIAGNOSIS OF CHOLERA.

PROFESSOR ROBERT KOCH has published in the *Zeitschrift für Hygiene* a communication on the diagnosis of cholera. He refers to the fact that the cholera vibrio is invariably present in cases of Asiatic cholera (a fact that Cunningham and other Indian observers still deny), and says it is not found under other conditions; so it is important that its presence should be easily and rapidly demonstrable. Where means have to be devised to prevent the spread of the disease, and an early diagnosis is essential, some more rapid method is required than that of plate cultures, that is most useful in cases in which the vibrios are present in large numbers and several days are available for the process of development.

Koch found that a rapid microscopic examination of the materials forwarded to him from various parts of Germany enabled him to telegraph, almost immediately in about half the cases examined, whether the patient from whom the dejecta were obtained was affected with cholera or not. A microscopic examination of the mucous threads and flakes shows the cholera vibrios arranged in groups in which the single vibrios run parallel like a shoal of small fish following one another in a stream. This appearance he considers so characteristic of the cholera spirillum that when it is present he does not hesitate to make the diagnosis. Dunham, of New York, suggested a one per cent. peptone solution with one half per cent. of sodium chloride as a medium in which the organism would grow, reducing the nitrates to nitrites and also forming indol in its growth, so that on the addition of hydrochloric or sulphuric acid the "red reaction" was readily obtained. Dunham also found that the cholera vibrio grew in this mixture at an enormously greater rate than the other organisms found in the intestinal tract, and, on account of the affinity of the vibrio for oxygen, an almost pure culture may be obtained from the surface of the peptone medium. Koch finds that a one per cent. is preferable to a one half per cent. solution of salt; and with this method, Hueppe's method of intraperitoneal injection, the gelatin and agar plate methods he was able to make a rapid and accurate diagnosis in all the cases submitted to him. It requires six hours to obtain the red reaction, and from eight to ten hours for colonies to be recognisable on the plates.

DIARRHŒA IN CHILDREN AND ITS TREATMENT.

By WILLIAM DUNCAN, L.F.P.S.G., &c.

[An Original Article specially written for MEDICAL REPRINTS.]

DIARRHŒA is a common complaint amongst children, and a great deal of infant mortality, in cities at least, is due to this cause.

It is not a disease *per se*, but rather a symptom or consequence of some pathological state. The function of the bowels may, however, be brought into morbid action by many agents that act on the human body, such as exposure to cold or wet, improper food, excess in diet, dentition, malaria, and many morbid poisons.

The discharge from the bowels of those suffering from the affection presents a variety of appearances and may give some clue to the treatment of the complaint. Some nosologists have attempted a classification of this so-called disease, based on the character of the alvine evacuations, dividing it into several varieties, but it is questionable whether such a classification is of any use, since the character of the stools does not depend on any certain or definite pathological condition.

The evacuations may be of a thin feculent character or they may be dark and bilious, watery, mucous, serous, chylous, or may contain food differing little in appearance from what such

was when swallowed. Very often, however, several of those states are combined.

Under the following divisions we shall briefly consider idiopathic diarrhœa:—

1. Diarrhœa due to the presence of irritant substances in the alimentary canal.
2. Diarrhœa in which the food taken is passed *per anum*, differing little in appearance from what it was when ingested.
3. Diarrhœa due to congestion of the intestinal mucous membrane.

In the diarrhœa caused by the presence of irritant substances, the stools usually present a thin feculent character, and there is some pain before each evacuation, with nausea and vomiting, but when the discharge has continued for some time the stools lose their feculent appearance and become of a mucous kind or liquid, ultimately becoming frothy.

This form of diarrhœa is generally brought about by swallowing stimulating or irritating substances, excess in food, and improper diet. In infants fed on the breast it is often induced by an unwholesome condition of the mammary secretion.

In the diarrhœa in which the food passes through the bowels almost unchanged the digestive, assimilative, and absorbent functions seem to be in complete suspension. This form frequently attacks children of a few years old, and if not soon checked the little patient passes into a state of stupor and exhaustion ending in death. The primary cause of this kind of diarrhœa is indigestion followed by loss of vital energy of the alimentary mucous membrane.

The diarrhœa consequent on congestion of the mucous lining of the intestines is induced by whatever causes an increased flow of blood to the mucous membrane, as chilling of the body and arrest of the cutaneous secretion. The stools are usually serous, and may exhibit various colours, and flatulence of the bowels is a common accompaniment, and sometimes thick gelatinous pieces of mucous are passed, the urine voided being small in quantity.

The treatment is of course based on the cause. If it be ascertained that the complaint is due to the presence of any irritating substance in the intestinal canal, such should be expelled. The diarrhœa in these cases should rather be promoted in order to get rid of the offending matter by a purgative, such as castor-oil. If it depends on milk of an unwholesome kind, the giving of such should be withheld, and a better quality obtained, and should it be found that the mother's milk is at fault, the child ought to be weaned.

In that form of diarrhœa in which the stomach and bowels have apparently lost all tone, with almost entire suspension of their functions, the line of treatment that would naturally suggest itself would be the exhibition of some reliable artificial digestive. Thus I begin the treatment in these cases by administering a purgative dose of rhubarb, followed in a few hours by Lactopeptine in divided doses at regular intervals, and I have found this mode of treatment very satisfactory. After exercising its cathartic properties, the astringent powers of the rhubarb then come into play. In some cases, however, it may be necessary to supplement this treatment by occasional doses of an astringent mixture, and I continue the Lactopeptine for some time after the disappearance of all symptoms.

A warm bath by causing a determination of blood to the surface of the body will be useful when the alimentary mucous membrane is congested in conjunction with other treatment.

If no direct cause can be made out, and the discharges are frequent and exhausting, they may be checked in whole or in part. For such a purpose a mixture containing tinct. catechu, spirit. chloroformi, and mist. cretæ is good, or pul. cretæ aromat. or liq. calcis may be given, and to relieve the pain warm poultices or fomentations may be applied to the abdomen.

APPENDICITIS.

By ROBERT T. MORRIS, M.A., M.D.

[A Clinical Lecture at the Post Graduate Medical School New York.]

GENTLEMEN: Before proceeding to remove the patient's appendix vermiformis, let us briefly review some of the salient points of these cases.

First.—Acute peritonitis in the male means appendicitis, no matter whether there is tenderness at McBurney's point or not. That is a rule. We may occasionally find an exception in a case of acute trichinosis, or on some equally rare complication; but the more one sees of appendicitis the less he sees of other causes for acute peritonitis.

I formerly made the diagnosis of acutis and perityphlitis and idiopathic peritonitis, but whenever opportunity came for real observation my cases all proved to be appendicitis in pristine purity of character. A physician of large practice not long ago told me that he did not have cases of true appendicitis. I had an argument with him upon the subject, and since that time have removed several perforated or sloughing appendices at his request. The patient was recently treated for three weeks as a case of typhoid fever. The appendicitis patient, who formed the subject for my lecture two weeks ago, was thought to have idiopathic peritonitis without known cause by a council of physicians, but you saw the true cause here. A physician has written me to-day, asking me to remove some gall stones for his wife; but the description of the case has led me to prepare for removing her appendix.

Second.—Appendicitis is apparently less common in the female than in the male, but there are many excuses for another diagnosis in women.

Third.—The reason why the symptom of local tenderness may be misleading is because the perforating appendix tip may be attached to the liver, or it may be in a hernial sac down in the patient's scrotum, or it may be rolled all in a heap with the left ovary tube.

In one of my recent cases the tip of the appendix was attached near its own base to the cæcum, which it had perforated, completing a hollow loop, like the handle of a Peruvian jug.

Fourth.—Anything that causes the mucous membrane of the appendix to swell may cause necrosis. The mucous membrane forms a soft, distensible tube within a tube of muscle and peritoneum, which is less elastic. A simple catarrh of the intestine may cause this mucous tube to choke itself to death within the inelastic tube. A seed or a fecal concretion may start the swelling, and I have no doubt that many cases of real typhoid and of dysentery die of appendicitis.

Fifth.—Whenever we have colicky pains in an attack of appendicitis I believe that it means spasm of the muscular sheath of the tube and a sympathising intestine. Sloughs, large or small, are usually thrown off from the mucous membrane of the tube in an attack of appendicitis. If they escape into the bowel, a granulating ulcer is left, and the patient recovers (temporarily). If the slough escapes through the walls of the appendix, the patient dies unless adhesions have protected him. If lymph exudate walls in the site of the perforation, an abscess forms, and this can be absorbed leisurely—lymph, pus, slough, and all—but it is so risky for the patient that we must not allow Nature to have her way.

Sixth.—The reason why we should remove the appendix as soon as the diagnosis of appendicitis is made is because we never can tell when or where perforation will occur, and we never know whether the products of inflammation are going to kill or not.

Seventh.—The reason why the appendix should be removed between attacks in recurrent cases is because the death rate ought not to be above one per cent. at such times, and the mortality rate must be much higher when we are dealing with perforations and large septic abscesses.

This patient wanted an operation after he had recovered from his typhoid fever, because there was a tender spot in the right groin that always needed protection. Besides that, he did not want to be constantly in dread of another attack of appendicitis. Aside from the danger and the dread of other attacks, he did not want to lose the time necessary for recovery from subsequent attacks.

In the case of two weeks ago the patient had been sent to me last year in an interval between attacks, and it was left to my judgment to decide whether to operate then or not. With that false idea of conservatism that is so hard

to overcome, I decided to wait until the patient had acute symptoms again. When the appendicitis again flared up, and after I had removed a suppurating mass of green lymph exudate and a rankly poisonous perforated appendix, the father of the patient came to me and asked if I had really used good judgment in deferring operation until that time.

In proceeding with the operation upon the patient who is before you, I hope that the reason for each step will be apparent without much explanation. In the first place, the patient is placed in Trendelenburg's posture, because that will allow me to separate adhesions, and to work by sight without disturbing the intestines. In a case two weeks ago, in which there was green fetid pus and a large mass of lymph exudate, Trendelenburg's posture allowed me to open four separate abscesses, and to clean out the abscess cavities with peroxide of hydrogen, and finally to skin out the "area of dulness" and the necrotic appendix in one lump without endangering the general peritoneal cavity.

The usual incision over the normal base of the appendix having been made, I now lift the appendix out of the peritoneal cavity, and you will observe that it is swollen and red. About an inch of the tip is free, and about two inches and a half of the tube are bound to the cæcum in a spiral form with very strong adhesions.

The mesentery of the protruding tip is grasped with forceps, and adhesions are stripped away until the appendix is entirely free. The mesentery of the appendix is ligated close to the cæcum, and I now snip through two coats of the appendix well down into the cæcum. If any appendix tissues were left, it would very likely perforate later beneath a ligature. The mucous tube now being put upon the stretch, it is ligated fairly down to the cæcal mucous membrane, and then snipped off close to the ligature. That cuts off danger of contamination from the intestine.

The next step consists in scarifying the peritoneum all about the vicinity of the knot with the point of a needle so that we are sure of an abundant exudation of cement after the sutures are in place. Sutures are now passed through the scarified cæcum in such a way that the old site of the appendix is deeply and safely buried with the Lembert closure. If we simply ligated the base of an appendix and did not bury the stump, you can readily see that that point would be the weakest part of the intestine after repair was complete. A sort of Eskimo window would be left, through which the intestinal microbes could peer out into the peritoneal cavity.

In closing the abdominal wound we follow a surgical law which demands that tissues be replaced in good order, and consequently I suture the cut margins of each structure separately, giving particular attention to the superficial fascia—the seamless bag which holds the patient's abdomen together.

This method of suturing saves time—not to-day, to be sure, for it has required more time than all of the rest of the operation. It saves time because we shall not have to do a secondary operation next year for the relief of a hernia at the site of the incision.

Our work having been completed, I now split open the appendix for examination. As the peritoneal and muscular coats are divided, the mucous-tube quickly springs into the incision, showing what pressure it has been subjected to. The mucous-tube being split, we find one whole seed and part of another covered with hard fecal matter. The seeds are evidently those of a small melon. Half an inch from the



FIG. 1.—Perforated appendix and "area of dulness" removed in one mass and showing the openings of two of the abscess cavities.

tip of the appendix there is a stricture which closes the canal, and which marks the point from which a mucous slough separated at some former time. Near the caecal end

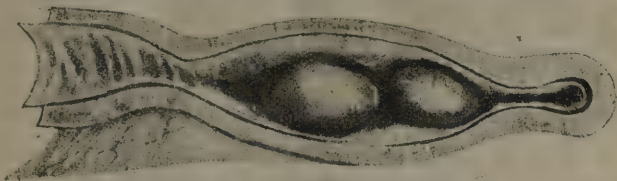


FIG. 2.—Appendix laid open to show contents and scar strictures.

of the tube another stricture, similar in character, effectually prevented the expulsion of the seeds. The mucous membrane of the pouch which contained the seeds is studded with red dots, showing what fires were smouldering there.

Note.—Since the presentation of this article for publication the author has completed a series of investigations which prove that appendicitis is an infectious exudative inflammation, commonly terminating in connective-tissue replacement of the mucosa of the appendix when the accidents of rapid necrosis do not cause a different ending.

DESCRIPTION OF A NEW SACRAL OPERATION PERFORMED BY PROFESSOR GUSSENBAUER.

By GEORGE E. ABBOTT, M.D.

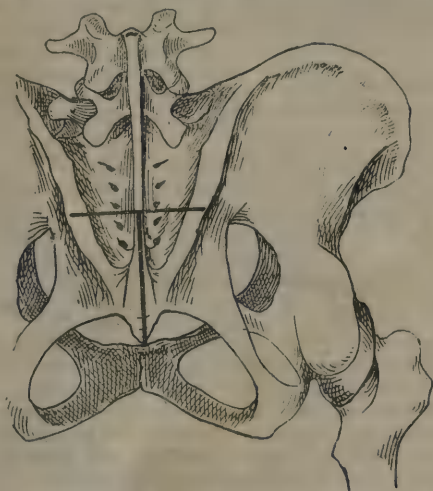
A FEW days since I had the pleasure of seeing Professor Gussenbauer, surgeon to the Imperial Royal General Hospital of Prag, perform his new sacral operation for resection of the rectum.

Although an operation upon the rectum, I have headed it "a sacral operation," for it is the technique of dividing the coccyx and sacrum in the median line and thus opening the pelvic cavity for operations upon its contents that constitute the originality and advantages of this procedure.

The patient was a man thirty-one years of age. Firm pressure upon the perineum, with counter-pressure upon the hypogastrium, enabled one just to touch the lower border of a hard, dense mass high up in the rectum. A diagnosis was made of cancer of the rectum.

The operation was begun by an incision to the bone, in the median line, from the tip of the coccyx up the sacrum for five inches (12 mm.) in length. This was converted into a T by a transverse incision also five inches (12 mm.) in length. There was but slight hæmorrhage. These flaps were not dissected up, but with a sharp saw, under irrigation, these same incisions were carefully carried through the coccyx and sacrum, the irrigation carrying the little bony chips out of the wound.

It will be seen that there had thus been made two triangular flaps of integument, still attached to the bone, each composed of one half of the coccyx and of the three lower sacral vertebrae. These were easily separated from the connective-tissue binding



of the peritoneum and carried to either side, giving a fine view and a large field for operation upon the pelvic contents.

Professor Gussenbauer was disappointed in finding the cancerous mass so adherent that he was obliged to abandon the resection in favour of total extirpation of the rectum.

Personally I was very glad, for as he extended his incision from the tip of the coccyx to and around the anus and proceeded with the operation, especially the latter part of the extirpation, I saw that his previous work gave him a marked advantage in operating, and that this increased room and facility of attacking parts high up or deep in the pelvis would be of just so much more advantage to those less skilful in operating.

The extirpation was completed and healthy gut brought down and sewed to the integument for a new anus, as usual. Then the bony flaps were returned to their places, being held by catgut sutures through the periosteum only, and silk sutures were passed through the integument. The inter-recto-coccygeal space was tamponed with iodoform gauze and the wound was dressed as usual.

The cancer occupied three inches (8 mm.) of the upper part of the rectum. I saw the wound dressed in the ward a few days afterwards; it appeared very healthy, and the patient was doing well.

At this writing, three weeks after the operation, the entire external wound has healed by first intention; pressure upon the lower sacrum and coccyx meets with a good resistance and produces no crepitation. The patient turns easily in bed and is in fine condition.

Professor Gussenbauer kindly allows me to send this report of the technique of the operation, although he is not yet ready to report upon the operation as a whole.

ON SUBSTITUTED DIGESTION

AS AN AUXILIARY IN THE TREATMENT OF DISEASE.

By GEO. SELKIRK JONES, Ph.D., L.S.A.

[An Original Article specially written for MEDICAL REPRINTS.]

MEDICINE, in common with every other branch of science as well as of industry, has, during the present half century, undergone much in the way of change and greater adaptability to modern requirements; in this regard it has but followed the natural lead of improved physiological knowledge, as well as that of drug compounding and chemical manufacture, for where the art of surgery has rendered possible major operations never before ventured upon in like manner has its twin brother medicine come to the aid of the expert pathologist and experienced physician. In connection with the subject before us, I take it that, *ceteris paribus*, given a normally acting gastric system, not only may we look for perfect assimilation of food material, but morbid substances, the by-products of mal-assimilation, can find no admission into the circulation, and to this end have modern therapeutics been directed, the goal aimed at being the production of a food more or less pre-digested or peptonised before introduction to the alimentary canal; indeed, so far has the trade in peptonised foods been pushed that, to quote from a remark made to me by a facetious friend the other day, "One may reasonably expect to see, at no very distant date, peptonised joints of meat exposed for sale in our butchers' shops with the announcements that 'all the meat sold at this establishment has been thoroughly peptonised and ready for use!'" In cases of atonicity of the digestive tract, due either to injury of its mucous surface, the result of error in diet, or to debility, whether as an heritage or the result of climatic influence—mental or neurotic causes—then artificial digestion may reasonably take the place of, or at least supplement, the natural function. I have already drawn the attention of the profession to a case of cardiac disease, complicated with much distress, the result of gastric and hepatic trouble, in which my efforts at its alleviation were considerably aided by the use of Lactopeptine, since when I have become much more interested in the action of this valuable drug. So much so, indeed, that I have been led to a series of carefully-conducted experiments with a view of satisfying myself upon certain points, all of which may be briefly summed up thus:—

First. Does Lactopeptine act as a solvent of albumen?

Second. Does its diastase (vegetable ptyalin) bring about the conversion of starch into glucose?

Third. Are fatty substances emulsified by the pancreatine, &c.?

In fine, does Lactopeptine act as an efficient substitute for the natural gastric secretion?

In my previous communication, the outcome of actual experience, in practice, Lactopeptine appeared to act most efficiently, but inasmuch as one is limited by actual results, in forming an opinion, such was therefore the basis of the one to which I referred.

But to the scientific mind more certain knowledge than

that obtained by clinical experience is required for building up a theory or substantiating an hypothesis; for example, if flatulent distention be absent, or at least mitigated by the use of this drug when taken after a meal, where formerly without it such a distressing condition was more the rule than the exception, such result could, to any reasonable mind, point but to one conclusion.

Again, should the patient experience a wholesome craving for food, where formerly the mere mention of a meal was distasteful, then have we good evidence of improved gastric tone. And again, if these conditions, apparently the result of the new medication, be continued and well sustained, what further need have we of witnesses? But although to the lay mind such may serve to prove the case, it is otherwise with the scientist, for may not, even to the patient, some doubts intrude as to the probable existence of another cause capable of producing the like effects? As, for example, any favourable change in the weather, increased ac-

tivity of mind or body, the reception of good news, or improved hygienic surroundings, &c., &c. Therefore the argument in favour of further research, especially of a more intimate and piecemeal character, will be readily conceded. Considerations, then, such as these having induced me to seek further light, I have been led to the performance of certain experiments of a purely chemical character, in order to leave no doubt in my mind with respect to the results already clinically obtained by myself. In conducting such experiments it was necessary to bear in mind that in order to arrive at anything approaching accuracy, such investigation must be made under conditions imitative of the natural process, as, for example, frequent agitation in place of peristaltic action, and a temperature of 98.5° F.—that of the human body; and, moreover, that each constituent of ordinary food should respectively be submitted to the action of Lactopeptine, supplied direct from the manufacturers. This has now been accomplished, and I am forced to the conclusion that Lactopeptine does act in the manner stated by colleagues, who have previously reported thereon. Briefly then, I am of opinion that this preparation approaches in composition and in action nearer to that of the natural secretions (the gastric, pancreatic, and buccal) than any yet experimented upon by me. Indeed, all the active principles of these are fairly represented by pepsine, diastase, pancreatine, lactic and hydrochloric acids contained in Lactopeptine.

I am therefore confirmed in my opinion that indigestion and atonic dyspepsia may successfully be combated by the prolonged use of Lactopeptine, taken within an hour after meals.¹

OXYGEN IN CHOLERA CURSORILY CONSIDERED.

By R. HARCOURT, M.D., Assistant Surgeon to the Demile Dispensary, New York, and District Physician to the New York Lying-in Asylum, &c.

THE various ways and means by which we are instructed to treat cholera are multiform; simple and difficult, practical and impracticable, partly successful and unsuccessful; but

¹ The substances taken for experiment were—Roast Beef, Boiled Bacon, Fat of both, Hard-boiled Egg, Bread, Starch, and Cheese.

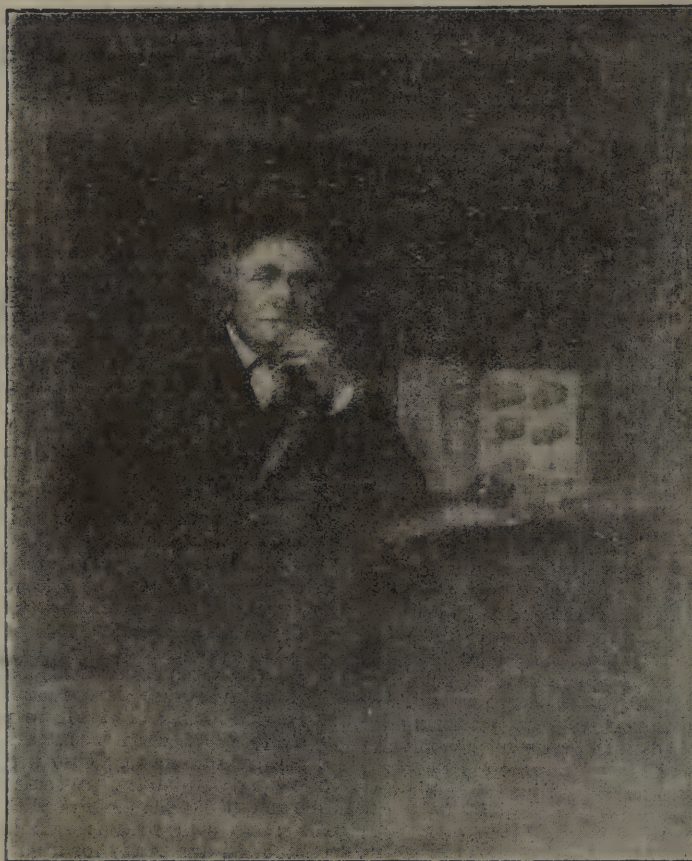
the fact that good results are, comparatively speaking, not often attained, justifies the belief that the profession will appreciate any suggestion which will tend to alleviate the suffering and misery of the patient, and to attain success in treatment. The wide divergence of opinion on both the subjects of ætiology and the treatment is due to a great extent, it must be remembered, to the difference in the character of various epidemics, in individual cases, and in the climatological situation and sanitary aspects co-existing.

It would be well to remember that there is no direct relation between the degree of collapse and amount of discharge; indeed, in the most fatal cases the discharges are slight or absent. The occurrence of collapse is the point against which we are to lead our remedial forces; in regard to the causes of the symptoms of which the conclusion is reached by a very able observer, that they are produced by obstruction of the circulatory fluid in its passage through the lungs. Post-mortem examinations show that in cases in which death

occurred during the stage of collapse, the right aorta, the pulmonary artery, and the great systemic veins were obstructed with blood, while the left aorta was found to be nearly empty. Blood containing the virus excites the arterioles to contract, the supply of oxygen is diminished in proportion to the defective current of arterial blood, the circulating blood and the tissue both become deoxygenated, the elimination of CO₂ is diminished, and there is almost complete suppression of bile and urine. That these symptoms are due to defective oxygenation is proved by the fact that, in the case of a nursing mother becoming infected with the disease and falling into collapse, the secretion of milk continues unchecked, the breasts even becoming painfully distended. The chief ingredients of the milk, viz., sugar, fat, curd, and water, unlike bile and urine, can be obtained from deoxygenated blood.

When it is considered that the soft tissues of the body contain four-fifths of all the water in the organism, it will be readily seen that the extraction of watery constituents from the blood will not cause it to become thickened, as it can draw on the reservoir

of water in the tissues, thus maintaining liquidity by compensation, the tissues diminishing in proportion to amount of water given up, which process takes place with great rapidity. If the body can be kept warm by any means, the painful cramps of the muscles will be relieved, the pulmonary arterial spasms will relax by heat of returning venous blood, and the pulse will be of a good character. The statement that Dr. Cuneo saved six patients affected with cholera by forcing oxygen into their lungs, shapes out a line of thought regarding this remedy as herein applied. As before stated, in this disease the symptoms of collapse are produced by obstruction of pulmonary circulation, which condition will bring about deficient oxygenation of both blood and tissues. Now, as it is of primary importance that we maintain normal animal heat, for which the necessity of oxidation of the tissues is well known (by oxidation is meant the application of the chemical law, that is, when a body is burning it enters into union with the oxygen), all tissues, as long as they retain their absolute integrity of composition, can appropriate oxygen and exhale CO₂. The blood being the only channel by which the tissues can be supplied with the gas, every means possible should be made use of to cause it to be taken up by the blood. The physiological law which says that blood will only appropriate



SIR JOSHUA REYNOLDS' PORTRAIT OF JOHN HUNTER.

(Specially photographed for "Medical Reprints" by permission of the Royal College of Surgeons.)

OUR ILLUSTRATIONS.

THE HUNTER CENTENARY.



BUST OF HUNTER.

(From a photograph taken specially for "Medical Reprints" by permission of the Royal College of Surgeons.)

a certain quantity of oxygen has to be carefully considered, but it will be remembered that in cholera an abnormal condition is present, namely, obstruction of the pulmonary circulation, in which condition, it is said, one lung often does duty for the two, by way of the blood it contains taking up a nearly double quantity of oxygen, clearly proving that in cholera the judicious use of oxygen would be one of the best resources which can be commanded; first, constitutionally as a tonic, and secondly, by assisting Nature in her conservatism by keeping up normal oxidation until she has thrust out the poison by way of frequent diarrhoeic discharges.

Probably the diseases in which oxygen has been of greatest value are pneumonitis and septicæmia, and there is not wanting literature testifying to the remarkable results obtained from the use of the gas in these abnormal conditions.

We have employed Lactopeptine in cases of obstinate dyspepsia, and have been gratified—even surprised—at the very excellent results obtained in the great majority of cases. —*Medical and Surgical Reporter*, Philadelphia.

In the treatment of diarrhoea, produced by imperfect digestion, we have had most satisfactory results from the use of Lactopeptine; also in cases of impaired digestion. This is one of the most valuable pharmaceutical preparations that has been placed in the hands of the profession. We take pleasure in attesting to its value. —*Cincinnati Lancet*.

This valuable preparation, Lactopeptine, has become so well known that we need scarcely call attention to its usefulness in all varieties of dyspepsia. It has also gained a high reputation in *cholera infantum*, so prevalent in our hot months, and in that other troublesome complaint that is always in season, vomiting in pregnancy. —*Canadian Journal of Medical Science*.

EXACTLY one hundred years ago to-day—that is to say, on the sixteenth day of October, 1793—John Hunter, at the height of his fame and of his magnificent usefulness, died suddenly in St. George's Hospital. He was addressing a board meeting of the Governors; an altercation arose, and Hunter was vehemently contradicted by a colleague. Hunter, to everyone's surprise, paused in his speech, and as suddenly hurried, without adding a word, from the board-room to an adjoining apartment. He staggered into the arms of Dr. Robertson, who assisted him to a couch. A few moments passed; the meeting broke off in consternation and confusion, and it became known that the great surgeon was no more.

From the Hospital he was carried to his house in Leicester Square. The bed on which he was laid subsequently passed into the possession of the late Frank Buckland, who had a chair made from the wood, and presented it to the Royal College of Surgeons—already rich in the relics of its benefactor—and it is now in the College building, Lincoln's Inn Fields.

Originally interred in the parish church of St. Martin's, his remains were, by a too tardy afterthought, removed in 1859 to the resting-place alone worthy to contain them, and Hunter lies in Westminster Abbey. The good he did lives after him—"Si monumentum queris," a visitor to the Royal College of Surgeons may well say, "circumspice." It is here that Hunter's collections have their home. By the conditions of his will, as is of course well known, they could not be divided. They were to be offered at a fairly negotiated price to the Government, and, failing purchase on equitable terms by the British nation, were to be disposed of, undivided, abroad. Parliament, not without a prolonged delay, saved this country the stigma of having to the final degree failed to appreciate them, and purchased the whole for £15,000, lodging the collection with the College of Surgeons.

In connection with the present centenary we publish in this issue new photographic views (prepared, by the courteous permission of the Royal College, especially for this journal) of the famous portrait of Hunter by Sir Joshua Reynolds and of the well-known bust which stands in the college building. In regard to the painting there is an amusing story. Reynolds found Hunter a very bad sitter. After several sittings, the painter was almost in despair of getting a good picture; but one day Hunter, whilst sitting, became deeply absorbed in thought, when Sir Joshua, seizing the opportunity, turned his canvas upside down, and the magnificent picture now in the College was the result. This picture was engraved by Sharp, and is considered one of that celebrated engraver's best works.

We also publish views of Long Calderwood, where Hunter was born, and of Earl's Court, his principal residence, together with a sketch representing a well-known relic of the great surgeon—the copper from the Earl's Court house in which the bones of O'Brien, the Irish giant, were boiled—a rather gruesome reminiscence. The story of Hunter's determination to possess the skeleton, of the difficulties placed in his way, and of his final and characteristic success in attaining his object, is well known.

It is neither necessary nor convenient in this place to attempt anything like an account of Hunter's life and work.



LONG CALDERWOOD.—BIRTHPLACE OF JOHN HUNTER.

He was born, as already mentioned, at Long Calderwood, which stands in the parish of Kilbride, East Lanarkshire, on February 13th, 1728, according to the parish register, though Hunter always kept his birthday on the following day—St. Valentine's. He came to London in 1748, and studied

friend and pupil, Jenner, show that he was ever on the watch for fresh materials; he never writes without asking for something. "Have you any eaves where bats go to at night? If you have, I will put you upon a set of experiments concerning the heat of them at different seasons." "Have you got the bones yet of a large porpoise? I wish you had!"



EARL'S COURT.—JOHN HUNTER'S CHIEF RESIDENCE.

at Chelsea Hospital, St. Bartholomew's, and St. George's. He obtained a staff-surgeoncy in the Army, and served at the siege of Belleisle and in Portugal. In 1763 he settled down to practise in London as a surgeon, and also began to lecture on anatomy and operative surgery.

Once permanently settled in London Hunter began to put together materials for that museum which, after his death, came to the College of Surgeons, and with which the name of Hunter will ever be associated. A series of letters to his

"If you can get me, easily, salmon-spawn, I should like to have it." "I rec'd yours, as also the Cuckow's Stomach. I should like to have a few more of them, for I find that they do not all show the same thing. If possible, I wish you could remove the cuckow's egg into another Bird's nest, and tame the young one to see what note it has; there is employment for you, young man. If you collect Eggs you should also collect the Nests, and I do not care how many you send. I wanted a Crow's nest, as also a Maggpy's in the branches of the Tree where they are built, but I am afraid it is now too late." This letter finishes, "I hear you are saying there is no end to your wants."

In a very interesting letter to the Corporation of Surgeons, Hunter urges upon the Court the necessity of forming a surgical library, and to make his letter practical, he concludes thus: "As the smallest beginnings may in the end lead to the greatest acquisitions, I have done myself the honour of presenting to the company, through your hands, the few observations on Anatomy and Surgery which I have published, and should the other members of that body be induced to follow my example, and by presenting their works establish a library which shall hereafter become both a public benefit and an honour

to the Corporation of Surgeons, I shall consider it as one of the happiest events of my life to have been at all instrumental in such an establishment." This last letter, and several other interesting Hunterian manuscripts which form part of the Stone collection, have lately come into the possession of the College of Surgeons through the generosity of Mr. T. Madden Stone.

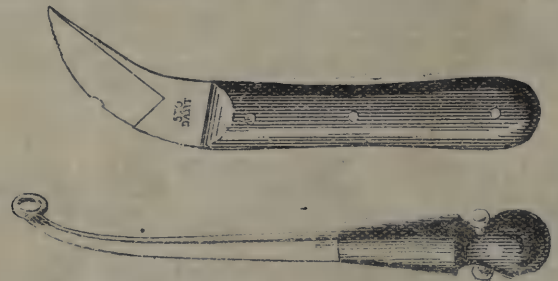
These are familiar as well as desultory annotations. It may not be so generally known that John Hunter once officiated, or undertook to officiate, in connection with a duel. Possibly his late arrival on the field of "honour" may not have been entirely undesigned. In one from *The London Packet* of December 17-20, 1784, we read:—"Yesterday morning, at ten o'clock, a duel was fought near the stand on Epsom Downs by Mr. Henry



TANKARD FORMERLY BELONGING TO JOHN HUNTER.



COPPER FROM HUNTER'S HOUSE AT EARL'S COURT, USED IN PREPARING THE SKELETON OF O'BRIEN, THE IRISH GIANT.



TWO OF HUNTER'S INSTRUMENTS.

Drummond, jun., banker, of Charing Cross, and Captain Battersby, of the 29th Regiment. When they came to the ground, it was agreed on between the seconds that the principals should stand at ten yards distance. Mr. D. fired the first shot, but without effect; after which Captain B. discharged his pi-tol, the contents of which entered at Mr. D's elbow and lodged in the wrist, from which it was immediately extracted by Mr. Kennedy, surgeon, of Great Queen Street, who attended on the part of Captain B. Mr. J. Hunter came as surgeon to Mr. D., but did not arrive till after the operation had been performed by Mr. Kennedy."

The silver tankard shown in one of our illustrations, was presented as a relic to the College of Surgeons by Captain Sir Everard Home, R.N. The more strictly professional objects of which we are enabled to present illustrations are a set of lancets, in a tortoiseshell case, a set of pocket-balances, a lithotomy knife, and an instrument of Hunter's invention for



HUNTER'S BUREAU AND CHAIR.

tightening ligatures. We also show a chair and bureau-cupboard. His chair (which, by the way, was made by Hunter's orders from wood brought home by Dr. Solander from one of Cook's voyages) figures in Dr. Goodsir's once famous brochure, "Only an Old Chair," in which the chair, dowered for literary purposes with the gift of speech, is made to give a satirical description of the fashionable recep-



JOHN HUNTER.—A SET OF LANCETS.

tions which Mrs. Hunter used to give, sometimes, according to contemporary scandal, much against the will, or without the knowledge, of her illustrious husband. Mrs. Hunter was a sister of Sir Everard Home, and was not unrenowned as a poetess. One of her songs, set to music by Haydn, is still deservedly popular—"My mother bids me bind my hair."

XXII.—A GALLERY OF MEDICAL PORTRAITS.

We produce, this week, a wood engraving of the late

DR. PARKE,

well known in connection with the African explorations of Mr. Stanley, who has paid so warm a tribute to the memory of his colleague. Death has been very busy among Mr. Stanley's comrades in the most famous of his expeditions. Surgeon-Major Parke has followed Barttelot, Stairs, and Nelson to the land of shadows. Dr. Parke's sudden death can be regretted by no one more than his old chief. Mr. Stanley is not a man prone to "gush," and his eloquent eulogy of Parke's character and services in Africa betray very deep feeling. There is little doubt that the explorer owed his life to the skill of the young surgeon, and he has lost no opportunity of testifying his gratitude. "This expedition," wrote Mr. Stanley in "Darkest Africa," "possesses the rarest doctor in the world. No country in Europe can produce his equal, in my opinion. There may be many more learned, perhaps, more skilful, older or younger, as the case may be, but the best of them have something to learn from our doctor. He is such a combination of sweetness and simplicity. We are all bound to him with cords of love. We have seen him do so much out of pure love for his 'cases' that human nature becomes ennobled by this gem. He is tenderness itself!" Everybody who knew Dr. Parke was struck by



SET OF POCKET SCALES BELONGING TO JOHN HUNTER.

the manliness and modesty of his character. He had won distinction before he joined Mr. Stanley, for he accompanied the Nile Expedition for the relief of Khartoum, and was present at Abu Klea as a member of the Army Medical Staff. Dr. Parke, who was a native of Drumona, in Ireland, and educated in Dublin, was only thirty-six years of age. To the literature of the Emin Pasha Relief Expedition he contributed a volume of personal experiences, not the least interesting of that group, and happily free from the scandalous and most painful controversies of some among them.

THE second portrait is that of the late

DR. CHARLES CLAY,

and is taken from a photograph presented by him to the editor a few months before his lamented decease, and executed by Mr. Milton G. Wilde, of Blackpool. Dr. Clay was born at Bredbury, near Stockport, December 27th, 1801, and was therefore within three months of attaining ninety-two years of age. In his early years he was articled to Mr. Kinder Wood, the first public lecturer on midwifery at the new Marsden Street School of Medicine in Manchester. He was a licentiate of the Royal College of Surgeons, Edinburgh (1823), and extra licentiate of the Royal College of Physicians of London (1842). His first fifteen years of practice, 1823 to 1839, were passed in Ashton-under-Lyne. In the latter year he removed to 101, Piccadilly, Manchester. In September, 1842, he performed his first ovariotomy operation on a patient who made a good recovery. In this year he performed the operation no less than four times, and twice was successful.

THE BRITISH MEDICAL JOURNAL says:—

"We have submitted the LACTOPEPTINE to trial, and can confidently recommend it."

THE MEDICAL PRESS AND CIRCULAR says of
LACTOPEPTINE:—

"Such a formula is a desideratum, considering that the preparations of Pepsin now in use have disappointed the expectations of many practitioners."

BRAITHWAITE'S RETROSPECT says:—

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PUBLISHER'S NOTE.

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

OCTOBER 16th, 1893.

In our leading article last month we called attention to a rather impudent attempt to impose upon the medical profession an entirely unauthorised mixture, in place of what we may even here not be thought egotistical in calling a well-known and trusted drug—LACTOPEPTINE, which has for some twenty years enjoyed the confidence of the medical profession. A peculiarly impudent attempt has been detected to foist even upon medical men (and with what success a similar attempt may have been made on patients themselves it will be rather harrowing to those who have their care to conjecture) a mixture which, whatever its qualities may be, is certainly not what medical men, prescribing LACTOPEPTINE, desire to be supplied to their patients; and since our last issue we have found reason to suppose that this remarkable proceeding has had a rather more extended field than had been previously imagined. With a view to the more complete exploding of the fallacy, we ven-

ture to ask that medical men receiving the letters or circulars, to which reference was made in our last issue, touting for sales of an imitative substitute for LACTOPEPTINE, will, for the common interest, forward them, in all confidence, to the proprietor of this Journal.

For it is to common interest that we appeal. Our own particular stake in the matter is, of course, a ponderable one, though in the case of an article as widely and almost universally used by medical men in all branches of practice—general practitioners and specialists alike—as LACTOPEPTINE, a thing of this kind would need to be a good deal more extended to make itself actually felt at headquarters. But the important view of the matter is this. A medical man, guided by the unanimous testimony of the medical journals, by the emphatic opinions of a large number of eminent medical authorities, and by his own experience, desires to put his patient under treatment by a drug of established repute and standing. The results usually looked for do not follow; and, on investigation, he finds that the innocent sufferer has been supplied, not with LACTOPEPTINE, but with a new-fangled and utterly unwarranted mixture, claiming to imitate its formula, which is, of course, a published one, perfectly well known to the profession and printed on every label. Surely this is no laughing matter. The medical man himself has been wronged; his skill has not had fair play. His orders have, through no fault of the patient, been disobeyed. And the patient himself has been very cruelly misled.

The remedy is clear. Medical men who keep a dispenser have only to direct the attention of that official to the importance of purchasing only LACTOPEPTINE in the one, four, and eight ounce bottles, in which it is exclusively supplied. Anything sold in bulk, or by the pound, as LACTOPEPTINE, is a fraud. Prescribers can direct the drug to be obtained in its original pink-wrapped ounce packages (which may quite conveniently be ordered for patients, and contain no undesirable printing); or when ordering LACTOPEPTINE in combination with other drugs should add the name "RICHARDS" to the prescription. For, whatever the composition of the substitutes may happen to be, they are not, and cannot be, LACTOPEPTINE, whose uniformity, palatableness, and well-established repute entitle it to the exclusive confidence which it enjoys among the medical profession of this country.

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NEWS AND NOTES.

THE surgical exhibits at the Chicago Exhibition are provoking much discussion in American medical literature. *The Medical Standard* begins an editorial with the following remarks:—"Visitors to the World's Fair will find the principal exhibits of medicinal preparations, surgical instruments, and other displays, of especial interest to physicians in the gallery of the Manufactures-and-Liberal-Arts building. The announcement is due both to the medical profession and the exhibitors, since there are so many objects of interest in the vast area of the ground-floor that the equally important display in the gallery is too often forgotten. The gallery is easily reached by numerous stairways, and in the variety, beauty, and richness of its exhibits will compare favourably with, if not excel, the other treasures of the Great Exposition. The medical, pharmaceutical, and surgical exhibits are a treatise, every page of which is replete with interesting demonstration of the marvellous evolution of medicine."

On the other hand, a letter in the French *Progrès Médical*, by Dr. M. Baudouin is quoted in a spirit of considerable irritation. Dr. Baudouin says that the medical congress which met in Chicago last May was a failure, partly because physicians from the East did not attend, and partly because of the diversion caused by the prospective congresses in Washington and Rome. He then directs his attention to the medical and surgical exhibits at the Fair. These do not, he says, compare at all favourably with the similar class shown in Paris in 1887. Only two large surgical houses had exhibits of much value. "The New York and Philadelphia surgical firms did not think it worth while to have themselves represented." The present exhibit consists of a "motley assortment of bandages, trusses, and glass-work, which show only too well the American habit of sacrificing everything to the useful." "How different," he adds, "to our Parisian products!" There are some surgical instruments which are "sufficiently original," but these are few. Most of the apparatus is essentially the same as that in Europe. The surgical instruments, he adds deprecatingly, are cheaply nickel plated. As compared with Parisian instruments, the American are less artistic, less elegant, and more clumsy. He refers here to the ordinary surgical instruments. As regards prosthetic apparatus, the French "remain the masters." Unhappily, he says, the Americans prefer cheap instruments. "It is only the surgeons of the Eastern hospitals who know how to appreciate the real value of elegance and the merits of Parisian productions." The fault with the Western surgeon, says M. Baudouin, is, in brief, that he has never seen a good thing, and hence does not know that he has not got it. Furthermore, "by reason of the patriotic vanity" [so conspicuously absent, interjects *The New York Medical Record*, in the French character] "which is the characteristic of the Yankee, he believes that whatever he possesses must be the very best."

BUT surely the patriotic *esprit de corps* of America can scarce quarrel with the comments of a critic from *The British Medical Journal*, who has visited the Exhibition, and who wrote thereon:—"The World's Fair at Chicago is replete with interest to everyone, and especially to medical men, sanitarians, and social observers. For, apart from its general artistic and industrial features and the unrivalled architectural and landscape attractions of the Chicago Exhibition, its ethnological, demographic, and medical and surgical exhibits are of surprising extent and completeness; and furnish abundant material for those who care to unite intervals of serious study with general sight-seeing on a great scale."

AN interesting case of recovery from a gunshot wound of the liver is reported from Dr. Closs, of the Dunedin Hospital, in *The New Zealand Medical Journal* for April. The number of recoveries after this injury is small. Longmore saw only one case of recovery during the Crimean campaign. Surgeon

Otis recorded four recoveries out of thirty-two cases. Dr. Closs's patient was a man, aged forty-two years, who attempted to commit suicide with a pistol. This occurred last January. The man was admitted into the hospital with collapse, from both shock and hæmorrhage, with much nervous excitement. The course of the bullet was from the eighth intercostal space in front backward and downward. The bullet, of the conical variety, was extracted on the same day, by an incision made close to the right side of the spine, on a level with the transverse process of the first lumbar vertebra. A drainage-tube was readily passed through the posterior incision about four inches, in a direct line with the wound or inlet. There was no escape of bile, and this fact is quite in accord with the records respecting many similar gunshot wounds. The external wound was kept aseptic, and a dry dressing was used. A slight amount of necrosis of the soft parts about the wound of impact took place. Jaundice and peritonitis were present during convalescence. The man was discharged from the hospital in twenty-four days after the wounding. The highest temperature was observed on the second day—102 deg. F.; the normal temperature was reached about the fourteenth day, and there were only trifling fluctuations after that date. The pulse and respiration were more variable. The ball had undoubtedly passed directly through the liver. When last seen, the patient was able to go about as well as he had done before the shooting.

A WELL authenticated case of extreme longevity is, according to the *Annals Hygiène*, reported from Mexico.

Margarita Rivera, grandmother of Governor Calan, of Coahuila, has lately died at Monterey, Mexico, at the age of one hundred and thirty-two. She was born in Spain, and came to Mexico over a century ago. She recently received from the Archbishop at Madrid a copy of the Cathedral record of her birth, which should place the alleged age beyond doubt. Her health for the past several years had been very feeble, and she was confined to her room.



THE LATE SURGEON-MAJOR PARKE.

DR. BLAIR, in *The Therapeutic Gazette*, draws attention to *ustilago maidis* (maize ergot) as a valuable drug in obstetric practice, and one which far excels ordinary ergot as an aid in tedious labour. It is prepared from maize affected with the disease known as "corn smut," and has been introduced into practice in the form of a fluid extract. The author has tried this preparation in a dozen cases of labour, with in most cases satisfactory results. The dose employed was from twenty to thirty minims. His general conclusions are as follows:—1. In those cases in which the pains were continuous, the effect of the drug was to make them intermittent and more easily borne. 2. Where natural labour pains were present and the extract was administered, the uterine contractions were increased in strength and labour hastened. 3. The effects were more favourable after considerable dilatation of the cervix had taken place, though the action of the drug was tested at all stages. In no instance were any bad effects produced.

AN American daily newspaper with a weakness for medical items, published the following remarkable statement in a recent cable dispatch regarding the illness of Prince Bismarck:—"The sciatica has now reached his arms and prevents him from using his hands, so that it is necessary for his attendants to feed him."

LAST year considerable excitement was created, as readers will remember, by a Parisian who had developed the pleasing power of emitting musical notes from—well, from a very unusual part of the organism for such a purpose. This year, if report is to be credited, medical science herself supplies a slightly similar though more seemingly curiosity. At the close of the Congress for the Advancement of Science the members of the Section of Medicine had a banquet. At dessert the venerable Dr. Schiff, of Geneva, who presided, entertained the company by playing the *Marsillaise* with the abductor muscles of his feet. Strong rhythmic contractions produced a sound audible for two or three metres.

AMERICAN OPINION.

IMPETIGO HERPETIFORMIS.

By M. B. HERMAN, M.D., Visiting Surgeon to St. Joseph's Hospital, Memphis, U.S.

E. McC—, aged twenty-three, married, American, of healthy parentage, her father and mother both living and enjoying good health; one brother has had dropsy, two years ago, but is in good health now. She began to menstruate at seventeen years of age, and has been irregular ever since, going sometimes for four months without a return of the flow.

In 1889 she had typhoid fever, lasting eight weeks. After her recovery her health had been good up to August, 1892, when she was attacked with severe pains and swelling in both ankle-joints, which was quickly followed by painful swelling of both knees and shoulders. Three months later, and while still suffering somewhat from arthritis, she was taken with a chill, fever, pains in her limbs, and nausea, and the following day noticed a vesicular eruption around her mouth and neck, which soon became pustular, and gradually involved the whole face, scalp, upper and lower extremities. She had no treatment up to February 28th, 1893, when, after a trip of seventy miles in an ox wagon, she was admitted into St. Joseph's Hospital, where she came under my care the following day.



Her hair was cut short and was matted together. The whole scalp was a mass of pustular patches covered with soft yellowish crusts, which, when raised, discharged a large quantity of very offensive pus. The face, back, and extensor surfaces of the arms, flexor surface of the legs, as well as the posterior and inner aspect of the thighs, were covered with brownish-black irregular crusts.

The neck, hands, and abdomen were free from any eruptions. Some discrete vesicles and pustules the size of a hemp-seed to a split-pea, and a few groups of pustules the size of a ten-cent piece were scattered over the sternum and feet. No areolæ surrounding the crusts were visible except over each knee. There was no pruritus, nor had there been any since the beginning of the disease, and then it was only slight. Patient was free from glandular enlargement. The removal of the crusts with a paper-cutter exposed red superficial ulcers slightly purulent. Patient complained of sore mouth and swelling of the gums and fauces. She said she thought that was due to pytalism caused from a dose of calomel which she had taken a few weeks before coming to the hospital. There was no abnormal flow of saliva at the time. The inability on the part of the patient to open the mouth, prevented me from making an examination of the fauces, but I am inclined to think that the lesions involved the

mucous membrane of the mouth also. She still complains of pains in her limbs and joints, but no swelling; both knees are ankylosed.

Her temperature when admitted into the hospital was 101° F.; pulse 126; bowels regular; tongue, as near as I could see, was clean; appetite fairly good, but could only take liquid food on account of her inability to masticate.

Two weeks after her admission into the ward she had a very severe attack of facial erysipelas; her temperature rose to 105½° F. for nearly four days; the face became very much swollen. The attack lasted six days. At first the improvement was slow, but after she was able to take nourishment freely the improvement became more pronounced.

As soon as the patient came under my care the crusts on her face and body were removed by the use of sweet-oil freely applied with a paint-brush, the scalp was cleansed with soap and water and a five per cent. solution of carbolic acid and poultices applied; these were covered with gutta-percha tissue and bandage and renewed daily. In a few days the scalp was entirely free from crusts, and the pustular patches were covered by a luxuriant growth of granulations. An ointment of white precipitate, grains x. to 3, was applied, but soon replaced by another of three per cent. carbolic acid, which was used continuously on the scalp, and alternately on each side of the body. Internally the salicylates were given until all pain in the joints had disappeared, when tonics, arsenic, strychnine, iron, quinine, and malt were substituted with a full nourishing diet. Her appetite improved very much; she was constantly asking for food. She gained very much in flesh and strength. The large superficial ulcers, which looked red and shallow after the crusts had been removed, formed into decidedly "elevated" irregular cicatrices, with occasional new crops of pustules at the periphery. These fresh eruptions were usually accompanied by a rise in temperature of from 1° F. to 1½° F. and slight anorexia, which, however, subsided in a couple of days. No new lesions had appeared for three weeks prior to her leaving the hospital. She was discharged, apparently cured, on May 21, 1893, and left for her home in Mount Pleasant, Miss., feeling perfectly well, and with the promise that she would keep me informed if a relapse should occur.

The case has been of great interest to me, as it is the first case of impetigo herpetiformis which has ever come under my care. This is only the second case reported in America.

According to Hardaway some thirteen cases have been reported, twelve of which proved fatal, and the patient that recovered suffered many relapses, and the two who recovered from former attacks died later from the same disorder. Eleven of the cases reported occurred in pregnant women. Of the thirteen cases on record, twelve were reported by Hebra and Kaposi, and one by Heitzmann.

A PREHISTORIC DENTAL ANOMALY.

By A. L. BENEDICT, M.D., Buffalo, New York.

I wish to record an instance of supernumerary tooth occurring in a skeleton—presumably that of an Indian—which was exhumed from a knoll near an old Indian corn-field on the east bank of Canandaigua Lake. Part of one or two other skeletons had previously been removed by the owner of the farm. No other remains were found; but the gravelly subsoil had been disturbed in an area six or eight feet in diameter by the insertion of clay and sand to the depth of about four feet. Throughout this inserted soil, charcoal (mostly oak, with one pine-knot) and calcined stones were found. At another spot in the same knoll there was uncovered a fireplace, circular and spherically convex, about three feet in diameter. A section through it showed four inches of charcoal and an equal thickness of baked clay. Immediately around and beneath this fireplace was shaley sand.

The skeleton lay on its left side, facing the west, the head pointing south. The arms were bent so as to bring the hands together near the face. The thighs were at right angles to the trunk, the legs flexed as closely as possible to the thighs. Judging from the development of the bones, the sutures, and the teeth, the skeleton was that of a medium-sized adult male in early middle life.

The supernumerary tooth was shaped like a stunted canine. The root, which was rounded off, projected slightly from the alveolar arch above the first right upper incisor. The crown lay in the anterior palatine canal, which was unusually large. This tooth was probably entirely hidden during life, though its possessor may have wondered what caused the little pro-

jecting knob under the gum. Certainly there was no caries or necrosis to indicate that a sinus led to either root or crown. The rest of the teeth were not remarkable, although some were decayed and a few missing. This case is in harmony with the observation that supernumerary teeth usually occur at the second dentition, in the upper jaw, and in connection with the incisors or canines.

A CURIOUS CONDITION OF THE BLADDER. ATONY?

By JAMES KENNEDY, M.D., San Antonio, Texas.

I HAVE quite recently had under my observation two patients upon whom I had operated, and whose bladders presented curious phenomena.

One was a lady upon whom I had performed both trachelorrhaphy and perineorrhaphy, and the other was a man upon whom I had practised stretching of the great sciatic nerve.

In the case of the woman, when the perineorrhaphy was completed, I introduced an ordinary female catheter with a view of emptying the bladder, but not a drop of urine would flow through the instrument. I withdrew it and introduced an elastic instrument, but still no urine would pass. I then made pressure over the pubes, and forced out some three ounces or more. The experiment was repeated twice daily for several days; and although the bladder might contain several ounces of urine, and the desire to micturate would be very intense, she could not relieve herself except in the sitting posture (and this was forbidden for the time); neither would any urine find its way through the catheter unless pressure over the bladder was made.

The man's case was very similar, though of shorter duration. I received an urgent call from him on the night of the same day that the operation was performed. He was suffering great agony on account of his bladder, and had an intense desire to urinate, but could not do so.

I introduced a metallic catheter without difficulty, but no urine would flow through it, although perfectly open. Flexible and soft rubber instruments were tried alternately, but did not succeed in relieving him until pressure was made over the region of the bladder. In withdrawing the metallic instrument, a few drops of urine would flow from it, showing without question that the catheter had entered the bladder. His bladder contained, on the occasion of which I speak, fully six ounces of urine, which I succeeded in drawing off only by persistent pressure over that organ. When the pressure was withdrawn the flow ceased, and recommenced when pressure was reapplied.

In both of these cases there was evidently a temporary absence of contractility. What produced this condition I am unable to say, unless there was paralysis of the afferent nerves supplying this organ produced reflexly by the traumatism to the parts operated upon. Inhibition was probably not interfered with, but when withdrawn by the patient's will, or by the introduction of an instrument, there was no force in the bladder walls to carry out the desire created by the pain occasioned by the pressure of the urine.

A DISCHARGE FROM THE MIDDLE EAR TEMPORARILY ARRESTED BY THE REMOVAL OF ADENOID GROWTHS FROM THE PHARYNX.

By ANDREW H. SMITH, M.D.

A LAD, twelve years of age, had suffered for two years from middle-ear disease, with a perforation through Shrapnell's membrane. The discharge was considerable in quantity, and very fetid.

He was found to have large adenoid growths in the pharyngeal vault, which were removed with forceps and scraper. Following the operation there was a rapid decrease of the discharge, and for a short time even complete cessation. But with cicatrization of the denuded surface the discharge returned, and soon became as abundant as before.

It seemed probable that the extended wound resulting from the operation had produced such active derivation from the middle ear as to suspend the suppurative action during its continuance.

CORRESPONDENCE.

ON CARBUNCLE AND ITS TREATMENT.

SIR,—You have done good service by calling attention to Dr. P. C. Barker's treatment of carbuncle by the hypodermic injection of a solution of mercuric chloride; but it is an error to state that such a mode of treatment is "entirely new."

Dr. Peter Eade, of Norwich, in *The Lancet* of March 28th, 1874, p. 439, recommended the insertion, through the points of suppuration, of a solution of one part of carbolic acid to four parts of oil or glycerine.

Since reading Dr. Eade's paper, I have followed the principle of his practice, but injected the B.P. Gly. acid. carb. by the hypodermic syringe. Supposing the central slough to be about two inches in diameter, I inject the carbolic acid glycerine into the mass through about eight of the little white slough-points, selecting those near the outer, red, hard zone which surrounds the central slough. The carbolic fluid will be found to well up through every part of the carbuncle.

The result has been that the carbuncles ceased to extend, and in a few days slough off, leaving a healthy surface. I cover the carbuncle with lint soaked in the same B.P. Gly. acid. carb.

I published a note on this practice in *The Provincial Medical Journal* of March, 1891.

Practitioners will find the principle of practice suggested by Dr. Peter Eade of great value. Carbuncles abort under the treatment, but I think that the use of the hypodermic syringe is an improvement on the insertion of lint.

From what I have seen of the success of Dr. Peter Eade's method, I do not doubt that Dr. P. C. Barker has had a great success with the mercuric chloride solution.

I have found that one thorough injection is usually enough, but no doubt in some cases it may be necessary to repeat it.

Yours truly,

WILLIAM H. PEARSE, M.D.

Plymouth, September 30th, 1893.

SIR,—I have great pleasure in adding my testimony to the utility of Lactopeptine in diseases of the stomach. I have used it repeatedly in cases of gastric derangement with marked benefit. I shall continue to recommend it as I have hitherto done.

Thanking you for the journal you have kindly forwarded to me at intervals,

I am, yours faithfully,

GEO. W. EGLINTON, L.R.C.P. and L.M., L.F.P.S.

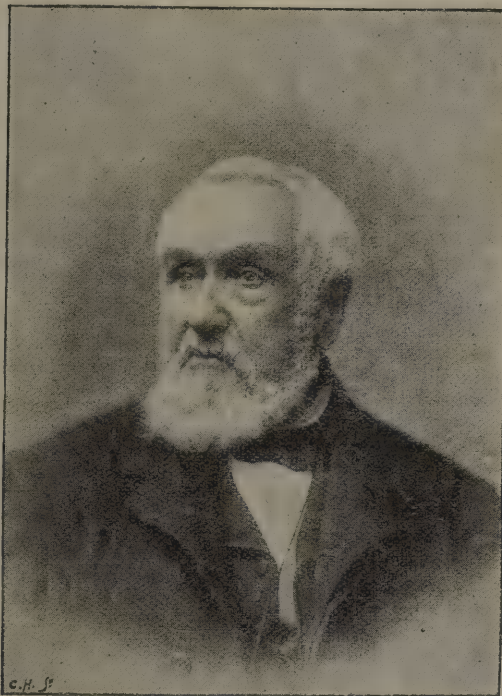
Street, Somerset,
5th September, 1893.

SIR,—I frequently prescribe Lactopeptine, and I always find it useful.

Yours faithfully,

JAMES HURLEY, M.D., Q.U.I., and L.M.

Queen Camel, Somerset,
6th September, 1893.



THE LATE DR. CHARLES CLAY.

DEAR SIR,—For the past fourteen years I have constantly used your Lactopeptine, and I have invariably found it most beneficial in its results and always most reliable. A patient of mine, whose age is ninety-nine years and eight months, has taken it regularly for thirteen years, and has never missed a dose on any single day for nine years. Without his usual dose he is unable to rest, as his digestive organs are quite unable to perform their necessary functions unaided, and your Lactopeptine is the only remedy I know which will satisfactorily carry on these duties.

I am very pleased to give you such testimony of its efficacy, and I do think my case is one worthy of recording.

Yours very truly,

ROBERT CLARK, L.R.C.P., L.R.C.S.

78, Church Street, Lancaster,
3rd October, 1893.

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

ASPHYXIA OF THE NEWBORN.—The following is a simple method to relieve asphyxia of the newborn:—Should I find the funis pulsating strongly, I wait until this has almost ceased, and then divide it. I then raise the limp and flaccid body of the infant, and, turning it face downwards, with arms and legs pendant, allow the thorax to rest across the open palm of my left hand, and at intervals of five seconds (which I measure carefully by counting slowly) compress the ribs with my hand, as one would work a rubber syringe. While my left hand is thus fully occupied, the position of the head allowing the tongue to fall forward and facilitate the escape of mucus from the mouth, I cleanse the lips of the infant with a napkin held in my right, and insert my index finger well into the pharynx, so as to establish the "atmospheric highway." I then proceed to change the child to my right hand, so that the tips of my fingers, resting near the heart, will at once detect any improvement in its action.

ALEXANDER DUKE, F.R.C.P.I.

Cheltenham.

SALICYLATE OF SODA has been found by Meynier to give prompt relief in gonorrhoeal inflammation about the neck of the bladder. A dose should be given every hour, and during the day as much as from six to ten grams. This is gradually decreased to three grams daily as soon as symptoms abate (usually by the second day).

RUPTURE OF THE BLADDER in litholapaxy may result from using the pump when the bladder is too full, or from spasmodic contraction when the urethra is blocked with instruments. The degree of resistance offered to the entrance of water should be carefully noticed when the bladder is injected before operation.

PERIPHERAL ANEURISM.—Extirpation of the sac has the advantage over ligation, that recurrences are excluded and gangrene is less apt to occur. The Esmarch bandage is not advised. When an aneurism's contents have been coagulated by remedial agents, extirpation may be required because of pressure on neighbouring parts.—*Berlin kl. Woch.*

TUBERCULOSIS OF JOINTS.—König believes that extirpation of the capsule alone, without removal of the joint extremities, is an unsafe measure. Bergmann commends iodoform glycerine injections, as does also Koch (Dorpat), who treated, in ten months, 367 cases of joint tuberculosis; 100 of these involved the hip-joint, 117 the knee-joint.

TREATMENT OF ECZEMA OF THE VULVA.—Lusch recommends the following prescription in this condition:—

B. Tincture of opium.			
Bicarbonate of sodium	...	...	aa 3 ij.
Bicarbonate of potassium	...	...	5 j.
Pure glycerine	...	...	5 jss.
Distilled water	...	...	5 viij.

Make a solution, and apply it hot, morning and night, to the diseased area. After each lotion powder the parts with the following:—

B. Finely powdered starch	...	...	49 parts.
Finely powdered camphor	...	...	1 part.

—*Therapeutic Gazette.*

ASTHMA.—At onset of attack, paint nasal fossæ as far in as possible with one part by weight of cocaine hydrochlorate to twenty of water, or spray nose and pharynx for four or five minutes. This may cut short the attack.—*DIEULAFOY.*

SODIUM TETRABORICUM NEUTRALE has been attended with more marked success in chronic suppuration of the middle ear than any agent which Heflebower has ever used. It seems to be antiseptic and astringent and is used in sterilised saturated solution as an injection.—*Cincinnati Lancet-Clinic.*

PRICE LIST OF MR. J. M. RICHARDS' MEDICINAL PREPARATIONS, &c.

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ELIXIR CAULOCOREA.

Formula:—Caulophyllum Thalioides; Viburnum Opulus; Viburnum Prunifolium; Aletris Farinosa; Dioscorea Villosa; Mitchella Repens; Spts. Ætheris Co. Emmenagogue, Parturient, Antispasmodic, Diuretic, Tonic. Price 4/6. To the Medical Profession, 3/9; post free, 4/- Sample gratis and post free.

GLYCONES, LILLY.

Glycerine Suppositories, in waterproof non-metallic covering. Infant or Adult sizes.—Kindly specify which size. Price (either size) 2/6 per box of 1 dozen. To the Medical Profession, 1/9; post free, 1/11. Samples gratis and post free.

HARVEY STATUETTE.

Fac-simile reproduction of the celebrated Statue by C. B. BIRCH, A.R.A. Height, 26 inches. Price, to the Medical Profession, £2. 2s.; Case for packing, 2/6 extra. Carriage at purchaser's expense.

LACTOPEPTINE.

Digestive. Formula.—Pepsin (pure), 8 ounces; Pancreatine (pure), 6 ounces; Veg. Ptyalin or Diastase, 4 drachms; Lactic Acid, 5 fl. drachms; Hydrochloric Acid, 5 fl. drachms; Sugar of Milk, 40 ounces.

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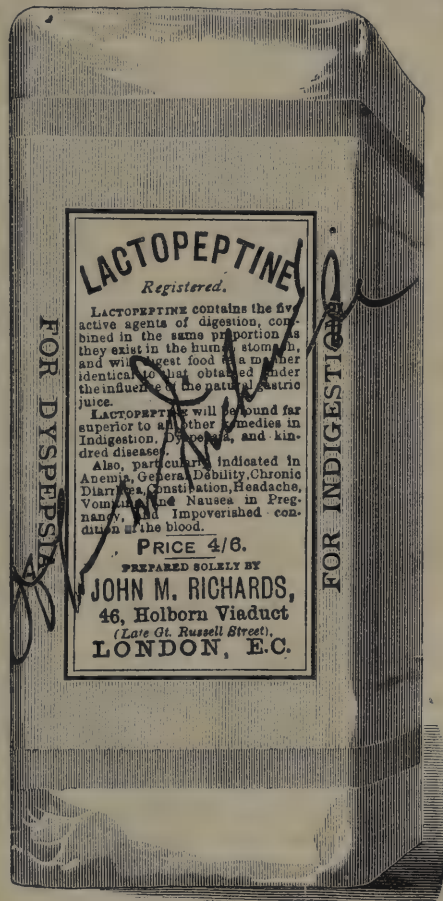
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THE LATE DR. HANFIELD JONES recommended and used *Succus Alterans*, and the last article published from his pen (in the "Medical Press and Circular") was a circumstantial account of its effect in a case under his care.

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Indicated in MENTAL OVERWORK, SEXUAL DEBILITY, IMPOTENCY. Decidedly beneficial in cases of NOCTURNAL EMISSIONS, the result of excess; in MENTAL APATHY or indifference, and in an ENFEEBLED CONDITION OF THE GENERAL SYSTEM, with WEAKNESS OR DULL PAIN IN THE LUMBOSACRAL REGION. Also act in the female as a UTERINE TONIC; hence, indicated in LEUCORRHOEA, AMENORRHOEA, DISMENORRHOEA, and to remove the tendency to repeated miscarriage.

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manufacture of PHOSPHORUS PILLS, a thorough subdivision of phosphorus in the mass is obtained, and, with a coating perfectly PROTECTING it from OXIDATION, there is nothing further to be desired.

From the "Medical Press and Circular."

LACTOPEPTINE

IN THE

GASTRIC DISORDERS OF CHILDREN.

By AUBREY HUSBAND, M.B., C.M., B.Sc., F.R.C.S.Edin., &c.

FREQUENCY OF SUCH DISORDERS.

Of all the disorders to which young children are liable, those affecting the digestive organs are at once the most common and the most fatal. It has been calculated from the Registrar-General's Report that one quarter of the deaths among children under five years is due to diseases of the digestive organs, and this fatality is considerably greater under one year.

THEIR FORM.

The vague terms *Debility, Atrophy, Inanition, Convulsions*, which help to swell the reports of the infant mortality of this country, all point to the inability to digest the food provided, and to draw from it the nutriment required for the development of the growing infant. This mortality is probably not due to any inherent complexity in the digestive organs of the child, but to the nature of the materials supplied as food, and it may confidently be asserted that the young of no other animal is subject to such a variety of dietetic experiments as that of man. Among the poorer classes of our towns these efforts to solve the problem of infant dietetics are unavoidable, and in most cases it is worse than absurd to lecture the people on the necessity for suckling their infants, or the keeping of their feeding-bottles sweet and clean. It is not as a rule the feeding-bottles that are at fault, but the materials which are placed in them, and which the force of circumstances compels them to use.

SOME CASES.

Passing from these general considerations, I would specialise one or two diseases, which, from their constant recurrence at the Royal Dispensary, Edinburgh, cannot but fail to attract attention, where, by the cordial assistance of Mr. E. Arthur Marsack, I was enabled to watch the effect of LACTOPEPTINE in their treatment. The cases were those chiefly of rickets, and of so-called infant atrophy, with dyspepsia and diarrhoea.

CASE I.

C. D., æt. three.—The little patient was brought by her mother to the dispensary with all the signs and symptoms of rickets. She had a heavy, stupid look, the chest much contracted laterally, and the bones of both legs and arms much affected. She vomited occasionally, but did not complain of any pain, but never smiled, and, in her mother's words, was "dwining away." She was ordered gr. v. of LACTOPEPTINE

after each meal, and under this treatment the child gradually and then rapidly improved, the mother frequently expressing her gratitude for the change in the health of her little one.

CASE II.

M. W., æt. two.—This child, when first visited, was found suffering with symptoms of gastric derangement, colic, vomiting, and loss of flesh. On inquiry, the fact was elicited that the diet consisted of anything that could be obtained, from a piece of cheese to a bit of dried cod or potato. As there seemed no chance of providing more suitable food for the child, it was hoped that by means of LACTOPEPTINE the diet might be made more digestible and nourishing. Acting on the suggestion, she was ordered gr. v. of the drug three times daily after food. The result was more favourable than was at first expected, and the treatment was combined as far as possible with regularity of habits, meals, &c. The little patient when last seen was quite well.

CASE III.

J. M., æt. seven years and a half.—This little lad appeared to be well cared for, but evidently of a strumous habit. He complained of no special symptoms, except that he always felt pain after taking food, and from the report of his mother was losing flesh rapidly. He could not take cod-liver oil. There were no chest symptoms. He was ordered gr. v. of LACTOPEPTINE, as in the former cases. The treatment was continued for about a month, but before that time he was able to take cod-liver oil without any return of the vomiting after each dose, which had before prevented its administration. He ceased to attend at the dispensary, and when visited was found to be quite well and able to go to school.

REMARKS.

The above cases, and several others which might be appended, serve to demonstrate the value of LACTOPEPTINE in the treatment of some of the gastric disorders of young children, and I may also state that I have found it of value in children far younger than those mentioned above. In two cases, the children of a mother in the last stage of phthisis, the mother declared that the lives of her babes had been saved by its use. In these cases the doses are, of course, much smaller than those given above.—*Medical Press and Circular*, London, May 30th, 1883.

Diseases of the Stomach.



By relieving the stomach of the work of digestion, LACTOPEPTINE, which combines in its formula *all* the digestive ferments in the human organism, affords the digestive organs an opportunity of recuperating suspended function. Its Pepsin exceeds in purity, activity, and freedom from the disagreeable odour and taste imparted to other pepsins by imperfection in manufacture all other digestive ferments ever produced. Its Pancreatine is of the same high standard, and it is proved by conclusive medical evidence that LACTOPEPTINE is not merely a single digestive, like Pepsin, fitted to palliate gastric inefficiency alone, but a perfect solvent of all human aliment, curing intestinal indigestion as well as ordinary Dyspepsia. Attention is directed to the remarkable consensus of medical authority in favour of

LACTOPEPTINE, which is used by medical men in all parts of the world as a remedy in Indigestion, Chronic Dyspepsia, Vomiting in Pregnancy (for which it is almost a specific), and all diseases arising from imperfect nutrition, such as Anæmia, Cholera Infantum, &c. Weakly infants thrive as if by magic under the influence of small doses of LACTOPEPTINE. See extract from article by Dr. Aubrey Husband, in *Medical Press and Circular* on previous page. A 4s. 6d. bottle of LACTOPEPTINE, for trial, sent free of charge to any medical man unacquainted with it, on request. The medical profession is warned that LACTOPEPTINE is genuine *only* when sold in the properly labelled and wrapped bottles of the manufacturer, JOHN M. RICHARDS, 46, Holborn Viaduct, London.



Lactopeptine.

MEDICAL REPRINTS

Home, Foreign, and Colonial: with Original Essays.

VOL. IV.]

LONDON: NOVEMBER 15TH, 1893.

[No. 46.]

NOTES ON CASES OF HOMŒO-OSTEOPLASTY IN THE SHATTERING DISORGANISATION OF COMPOUND FRACTURE OF THE LEG, THIGH, AND HAND.

By THOMAS H. MANLEY, M.D.

In serious cases of compound fracture of a limb attended by loss of bone substance we are often required to promptly decide on the adoption of such measures as will save life and afford us the best prospect of saving the limb. In the main, under these circumstances, there are but two procedures open to us—first, *immediate* amputation; and second, delay and the application of such a tentative therapy as will enable us to spare every particle of such tissues as may later serve a useful purpose.

After considerable experience with many very extensive mangling fractures of the extremities of every description, I am led to conclude that in the present advanced state of modern surgery a primary amputation in civil life is never a justifiable procedure unless the initial vulnerant force applied has been so great as to *totally* destroy the vitality of tissues beyond the line of injury—in other words, unless the physical force has in itself effected practically a traumatic amputation. In other recent contributions¹ I have fully and in detail endeavoured to clearly set forth my position in this particular; defined the class of cases in which the greatest success may be attained, with a varied technique and therapy, which, when instituted, is attended with good results; and demonstrated, both by an appeal to the most noted recent authorities and the citation of a large number of cases, that we must under *all* circumstances practise extreme conservatism in all cases of serious fractures accompanied by extensive disorganisation of substance.

The cases here described were attended by me within the past six months.

The most interesting of the group I will present first.

CASE I. *Compound Fracture of Left Tibia; Removal of Three Inches and a Quarter of Shattered Shaft, with a corresponding Segment of the Unbroken Fibula.*—Patient, Mr. C. B., aged thirty-nine years, of medium height and good general health, on the 30th June, 1892, while descending a staircase, slipped and fell to the bottom. As he was unable to rise after the accident without assistance, he was lifted up, placed in a conveyance, and sent to his home. Here he was attended by his family physician. Not having very good success in the management of the case, and finding that the patient's general condition was becoming seriously disturbed, the doctor sent him to the Harlem Hospital. When the case was seen by me (July 4th) in hospital, and I discovered the extremely serious nature of the injury, before instituting any special line of treatment other than securing the parts in a comfortable temporary adjustment, I sent for the family physician to again see the rather hopeless sort of case we had in our hands—as far, at least, as the saving of the limb went—before we should undertake any sort of serious operation on him.

The tibia had been broken about four inches from the ankle joint. Both the proximal and distal ends of the fragments were comminuted, and were projecting through a large breach in the integument along the inner aspect of the leg. More than three inches of the tibial shaft protruding was of a lustreless, charred appearance, completely denuded of its periosteum. The foot and leg were greatly swollen, and the appearance of the wound was most unpromising. Its surface was bloodless, of a gray hue, abundantly discharging an ichorous, foul-smelling fluid on the least pressure.

His general condition was not good. Already symptoms

of incipient wound infection and constitutional irritation were manifested by the quick pulse, flushed cheek, and high temperature. He had a good heart, however, with plenty of "nerve" and will power, and was ready to submit to anything that might be done which would preserve the leg.

Now the question arose, What was to be done that would secure the best prospect of future locomotion and save his life?

Well, if we were to institute that measure which would the most promptly rid him of the mass of irritable tissue and effect prompt union, the answer would be, Amputation and an artificial limb. But how few ever secure a stump that will bear an artificial limb with any degree of comfort; and, even though they do about once in ten cases after amputation through contiguity of tissue in the leg, what a miserable substitute the most perfect prosthetic apparatus is compared even with an ankylosed ankle!

After careful deliberation, and anticipating many of the dangers in the way of resection, it was decided to utilise modern osteoplastic procedures and endeavour to preserve the limb.

It must be remembered that the fibula was yet whole and unbroken. We might, it is true, have removed the *débris* of the broken tibia and left a gap in the tissues, but the limb would have been useless for either motion or pressure. So we might have plugged the breach with decalcified bone chips; but, though these might be covered in in time by a temporary cicatrix, yet they are as much a foreign substance as the bone about to be removed.

Heteroplastic bone grafts were quite out of the question, for the bone elements of man will not mingle and assimilate with those of a lower animal.

It was decided then to cut away all the disorganised bone of the tibia and remove sufficient of the fibular shaft to permit the transverse surfaces to come evenly together; in that manner to secure solid union, though at the expense of the length of the leg.

Operation.—On the afternoon of July 5th, after having had the patient prepared and the limb in readiness, I commenced by pushing out the lower fragment to its uttermost, in order that the chain saw might engage at the broad, unbroken surface of the distal fragment, just above the epiphyseal line, when it was cut through, leaving a wide, vascular bone surface. The proximal fragment was treated in a similar manner. Now the fibular shaft was sought for, and it was intended to reduce its length by such an excision as would permit us to oppose the tibial surfaces. But, as seen in the cut, we had to remove a second piece before this end was secured.

After the sawn surfaces of the bone shafts were brought together, one heavy silver wire suture was introduced deeply into the free ends of the tibia, which secured them firmly together, after its ends were twisted.

The periosteal coverings of the divided tibia and fibula were now carefully sewn together around the hiatus, in the tibia and fibula, and then the tissues were, each layer homologously, opposed and sutured until the integuments were reached. Through all, down the bone, an ample drain-vent was left. At this stage a plaster dressing was applied. Fearing the troublesome secondary excessive oozing so common after permanent dressings are applied when Esmarch's constrictor is used, we need not employ it.

Our man was on the table, under ether, a little more than an hour. He reacted well, and, though his complete recovery and the return of the full use of his leg have been tedious, he has been rewarded for the time lost and expense entailed thereby by the preservation of his leg.

Ultimate Results as to Locomotion and Strength of the Limb.—The bones now are solidly united, and he is able to attend his place of business and stand unsupported on his limbs from morning until night.

In the beginning of November he had a shoe specially made for the injured leg. This was so constructed as to give

¹ Resection as a Substitute for Primary Amputation (*New England Medical Monthly*, May, 1891); A Study of Osteogenesis from a Pathological Standpoint (*Medical and Surgical Reporter*, July, 1891); Osteogenesis and Osteoplasty in Crushing Lesions of the Extremities (*Buffalo Medical and Surgical Journal*, November, 1892).

firm support to the ankle, and, by extending the broad, strong, lateral welts up to the knee on firm lacing, some of the weight of the body was in this manner borne by the knee joint directly. As there were removed just three inches and a fifth of bone shafts in their vertical diameters, hence, in making the shoe, a cork-sole lift, corresponding to this loss, was built up from below.

He has now no pain or discomfort of any kind.

Under date of February 2, 1893, he writes to me that at the time he was injured he was crippled with rheumatism in the joints of both his legs, and had been a victim to this malady for many years; but that since he was injured his rheumatism has entirely left him. Accordingly he inquires, "Do you think that the operation on my leg cured me of my rheumatism?"

And he adds: "If any one doubts the present strength and use of my leg let him come forward; and, as I can now give him a good kicking with it, he will soon change his mind."

"The little bone," he says, "which you expected, came out yesterday, much to our relief; and let me assure you that we gave it a right royal welcome, as it no doubt is the last of its race."

It must be confessed that for the remarkable result and the preservation of Mr. B.'s leg, we are largely indebted to our nurse, his excellent wife, through whose faithful care and unremitting

But his general condition was at this time very unfavourable to a capital operation. There was a high temperature, and his pulse was very quick. Indeed, his case presented a most serious aspect. Nevertheless, if the cerebral lesion was not extensive, with the dead limb off there was a glimmer of hope of saving his life. Therefore, after carefully considering the case from all sides, it was finally decided to moderately etherise and do a quick circular amputation through the lower third of the femur.

With this object in view he was brought into the operating room. Scarcely an ounce of ether was given, however, when he suddenly ceased to breathe, and was dead.

In reviewing this case in my mind, and its sudden termination, my only regrets have been that I deviated from my usual course and did the resection with the primary dressing while my patient was in shock. This was done because it was thought that while there were so many vessels to ligate



FIG. 1.—Anterior internal aspect. 1. Segment corresponding in size and situation with that removed. 2. Scar of internal incision. 3. Horizontal patella line. 4. Line corresponding with heel-surface raised.

attention very much of our success is attributable.

I may add, in conclusion, that this case was one which has demonstrated the enormous advantage of homœo-osteoplasty in those serious, complicated, compound fractures in which heretofore the usual procedure has been immediate amputation. I can find no parallel case in the annals of American surgery. In Ollier's great work, among the many cases of osteoplasty there cited are many similar ones; but they were all of a constitutional or pathological origin, and do not belong to the category of traumatism.

It may be added that in any other case of a similar description in a healthy child or adult, in whom there is a "cushion joint" (a pseudarthrosis) with loss of bone substance following a bone injury of the leg, it may be as safely dealt with, with as good prospects of satisfactory results, a month, a year, or more after the primary injury as immediately after the accident, when osteoplasty is resorted to and skilfully employed.

CASE II. Compound Comminuted Fracture of the Tibia with Simple Fracture of Fibula, besides a Cranial Fracture; Primary Resection of Bone and Adjustment; Acute Gangrene; Preparation for Amputation; Death under Ether.—Patient, aged thirty-one, a heavy-built, swarthy, vigorous man, while on a "bender" during the Christmas holidays fell through a bulkhead, sustaining the injuries above stated. He was admitted to Harlem Hospital, December 26th. There were evidences of fracture of the base of the skull, though he was rational. On examining the leg (right), it was found that he had a compound fracture of the tibia with extensive shattering, besides a simple fracture of the fibula which was not displaced. The parts were treated immediately on admission, as the preceding case.

He came out of the anæsthesia well and passed a good night. There was nothing of special note through the day succeeding, except an incoherency of speech and mixed symptoms of *delirium a potu* and cerebral injury.

On the evening after admission, on looking closely at the toes of the injured leg, which were cold, it was seen that they were of a deep purple and bloodless. In other words, gangrene had set in. Removing all the dressings, it was apparent that mortification had extended up as far as the knee, and that there remained no alternative but an amputation.



FIG. 2.—Showing a symmetry in length. 1. Line through the horizontal plane of the lower limbs, in the sitting posture. 2. Cork-sole shoe with a three-and-one-fifth-inch lift.

and so much shattered bone to remove, it would add but little, if any, to the collapse to do the resection and make the adjustment. But this, I am convinced, was a serious mistake. Although a post-mortem was refused, as he had free hæmorrhage from both ears with symmetrical ecchymosis, there is little doubt of a skull fracture.

CASE III. Compound Comminuted Fracture of the Femur, Upper Third; Reposition of Fragments; Recovery.—Patient, a young man nineteen years old, was injured by a fragment of board rebounding from a circular saw, hitting with great violence in the left groin. He was admitted July 22nd to the Harlem Hospital.

He was in considerable shock when admitted. The left lower limb was in the position of typical femoral shaft fracture. At seat of injury, projecting through integument at inner border of rectus muscle, was a spiculum of the shattered bone projecting.

As the fracture was within but about three inches of the upper epiphyseal line, the immense number of powerful muscles in the trochanters had full play on the superior fragments. In this case the temptation to enlarge the opening and do an osteoplasty on the displaced fragments and spike them together was very great. But a former acquaint-



FIG. 3.—Standing position. 1. Horizontal line through centre of patellæ. 2. Horizontal line under one ankle joint and over the other.

ance with traumatic lesions of the femoral shaft had taught me the important lesson that the femur, of all the bones in the human body, is the one in the skeleton which will not bear manipulation with impunity after fracture.

Dr. James R. Wood used to say that "he took off his hat to the peritonæum;" and my experience has led me to have a very respectful regard for the fragments of a broken

femur. I have seen one case in which on non-union the fracture was cut down upon by the surgeon, when the ends of the fragments were chiselled and wired. The patient narrowly escaped with his life, remained eighteen months in bed, and got up with an ankylosed knee joint and non-union of the fragments again. Another eminent surgeon whom I saw refracture a distortion of the femur after vicious union informed me that a sort of union followed after considerable time, but that the limb was no better than before operation. Hence in this case, with the exception of replacing the fragments and adjusting of the limb, nothing was done. The usual attitude was maintained, and the young fellow made an uneventful recovery, leaving the hospital October 3rd with two inches of shortening in the injured limb.

CASE IV. Compound Fracture of the Three External Metacarpal Bones of the Left Hand, with Complete Shattering of all the Phalanges of the Little Finger; Railroad Accident.—Patient, aged twenty-one years, a brakeman, came under my care November 21st. While coupling cars at White Plains, N.Y., his left hand was crushed between the buffers.



FIG. 4.—1. Proximal fragment of tibia sawn off. 2. Distal fragment of tibia sawn off close to ankle joint. 3. Section of fibula (sound) sawn through. 4. Section additional rendered necessary. 5, 6, 7, 8, 9. Shattered fragments removed from hiatus.

Immediately after the accident there was considerable hemorrhage, but by tight bandaging it was sufficiently subdued, and he was at once sent to this city. When he came under my notice, six hours after the accident, he was suffering from severe shock, and the mangled hand, with the many fractured ends of bone projecting through its dorsal surface, at first sight seemed hopelessly destroyed.

The little finger was reduced to a mass of pulp. Its metacarpal bone was fractured in its centre. The fourth metacarpal was torn completely out of its socket at the metacarpophalangeal articulation. The third metacarpal bone in its distal third was fractured and shattered into the articulation with the first phalanx of the middle finger. The entire palmar cutaneous surface of the hand was unbroken.

In this case, after a careful examination, I felt justified in promising to be able to save sufficient of the hand to serve as a useful member, provided there was not an extensive loss of integumental covering in the event of an extensive slough. It was evident on inspection that though there was considerable disorganisation and displacement of bone,

yet, with a few exceptions, all the fragments maintained intimate attachments with the loose adjacent tissues. Hence it was assumed that with reposition their vascular feeders would preserve their vitality and aid in the process of repair. The crushed finger, traumatically amputated, was removed, with its stump left to heal by granulations. The fragments of the third metacarpal bone were resected, but great care was observed to preserve its periosteum. All the other fragments were replaced and parts aseptically dressed and splinted. In this and none of the other cases were any antiseptic solutions employed.

Our patient, though not quite well yet, promises in the near future to have a fairly useful hand. There will remain some stiffness and impairment of strength, but it will be a hundredfold more useful than would be any sort of an artificial substitute.

THE STRONGLY COUNTER-IRRITANT EFFECTS OF THE USUAL MASTOID OPERATION.

By ALBERT H. BUCK, M.D., Clinical Professor of the Diseases of the Ear, College of Physicians and Surgeons, Medical Department of Columbia College; Consulting Aural Surgeon, New York Eye and Ear Infirmary, and the Presbyterian Hospital.

[Read before the American Otological Society, July, 1893.]

The main object kept before the mind of the surgeon in opening into the mastoid process is the establishment of a free channel between the outer world and the centre of disease, which latter, in most instances, is situated either in some part of the middle ear or in the mastoid bone itself. Through this channel the products of inflammation find a much easier way of escape than by any route that Nature may establish through ulcerative action, and through it, besides, the surgeon is able to introduce such remedial or mere cleansing fluids as he may think likely to exert a curative effect. But in certain cases, and they are by no means rare, the good effects of the operation are not confined to the benefits directly attributable to good drainage and thorough cleansing of the parts; the derivative or counter-irritant influence of the operation plays, I believe, a very important part in effecting a cure of these cases, and it is for the purpose of directing attention to this point that I have prepared the present paper.

Setons and issues were looked upon as valuable therapeutic agents even so recently as twenty-five years ago, but nowadays one scarcely ever hears them mentioned. In operating upon the mastoid we may establish an issue on a comparatively large scale. A gaping wound two or three inches in length is made in the skin, and a pit large enough to admit the end of the forefinger is excavated in the underlying bone itself. This deep excavation may be left gaping, and afterward, for a time at least, be treated as an open wound. When this course is adopted we have all the essential conditions of a large issue, and if there be any virtue in the principle of counter irritation, the beneficial effects that flow from it will be provided in liberal measure to the patient thus operated upon. On the other hand, if the edges of this gaping wound are stitched together in accurate coaptation, only a small outlet for the discharge being left at the lower angle, and then if, in addition, such dressings are applied that no micro-organisms can by any possibility find an entrance into the wound, our patient will certainly be deprived in large measure, if not wholly, of whatever good effects counter irritation is competent to supply. In the majority of cases, as I have already intimated, the disease will be cured without the aid of such additional counter irritation, but in those cases in which the disease of the ear has set up more or less active intracranial inflammation, this counter irritant power may be sufficient to turn the scale from a fatal to a favourable issue.

While I cannot hope to furnish from my case-book convincing proofs of the correctness of this doctrine, I believe that the histories of the following three cases will go far towards establishing its soundness:—

CASE I.—The patient, a vigorous man about thirty-eight years of age, consulted me in March, 1890, for the relief of a discharge from the left ear, of at least thirty years' standing. Aside from the discharge and some impairment of the hearing, the ear, he said, had given him no trouble until within a few days, when a certain amount of bleeding became associated with the discharge, and had continued since. On examination I found the left external auditory canal filled with a large and very vascular polypoid growth. I removed it with a snare, and found that it sprang from what was left of the drum membrane, in the neighborhood

of the hammer. I recommended the daily use of Angelo's ear-douche, and under this *régime* the ear gave him no further trouble during the subsequent three years.

On April 15th or 16th of the present year, he sat at an open window, with a current of air blowing upon the left side of the head. Soon afterward the ear became painful, and the pain continued to increase steadily until the 18th, when he called upon me to obtain relief. On examination I found that the upper cutaneous wall of the left external auditory canal was markedly prolapsed. There was a scanty, rather thin, pinkish, foul-smelling discharge in the canal. The body-temperature was 103° F., and the pulse 102. The pain was referred to the deeper parts of the ear, and to the whole left side of the head. There was no tenderness over the mastoid region.

The treatment adopted, and carried out by my associate, Dr. Robert Lewis, was the following: A free, curving incision was made across the cutaneous wall of the canal at the point of greatest prolapse, and through this opening a slightly curved silver canula was introduced. Through this a stream of a 1 to 4,000 bichloride of mercury solution was forced by air pressure generated through the instrumentality of a rubber foot-bag. This irrigation brought away an appreciable quantity of foul, cheesy material: the stream apparently escaping directly from the middle ear. Three leeches were also applied behind and below the ear, as close as possible to the auricle; and the patient was instructed to have hot linseed poultices applied continuously for three hours. Internally he was given one grain of calomel, to be followed, the next morning early, by a full dose of Rubinat Condal water.

On April 19th the patient was found to have less pain, and the temperature had fallen to 102° F. The probe, passed through the opening in the prolapsed portion of the wall of the canal, encountered everywhere roughened bone. Dr. Lewis therefore attempted, by passing a small-sized Volkmann's spoon (bowl = 3 mm. in diameter) through the artificial opening, to gnaw away so much of the intervening ridge of bone—presumably carious—that the stream of water from his canula would play directly upon the contents of the antrum. In this he apparently succeeded, for in the subsequent washing he drove out considerable quantities of foul, cheesy material.

During the next two or three days all the local symptoms improved greatly. The discharge almost entirely lost its foul odour, the prolapsed wall of the canal returned to its natural position, the temperature and pulse became nearly normal, and the pain had very decidedly diminished in severity. The appetite, however, did not return, and the patient showed no desire to leave his bed. His tongue also remained heavily coated. The urine had been examined by his regular medical attendant, Dr. Samuel K. Lyon, and found to be normal.

On April 25th the temperature again rose to 103° F., and the patient seemed to have passed into a state of semi-stupor. As the ear had improved so markedly, it was thought that there might be a malarial element underlying the rise in temperature and the mental hebetude. Accordingly quinine was administered in divided doses until he had taken, during the twenty-four hours, twenty grains. An ice-cap was also kept constantly applied to his head. These measures produced no perceptible effect upon either the temperature or the drowsiness, and at the suggestion of his physician he was given two doses (about four hours apart the one from the other) of the hydro-bromide of hyoscine, 1-120th grain in each dose. This was on April 26th.

On April 27th the patient was found to be greatly improved in every way. The temperature had fallen to normal. The drowsiness had disappeared, the dusky colour of his face had changed to a natural ruddy hue. His eyes were bright. He

asked for food. In a word, he seemed at last to be on the high road to getting well.

The visible parts of the ear having shown no signs of inflammatory action for at least three or four days, and apparently not requiring any other treatment than the frequent use of the warm douche with a very weak sublimate solution, the patient was left in the charge of his regular attendant.

As we afterward learned, the improvement noted above lasted only about twenty-four hours. The fever and drowsiness then returned, the right side of the body became paralysed, and the patient died on the third or fourth day after we had last seen him.

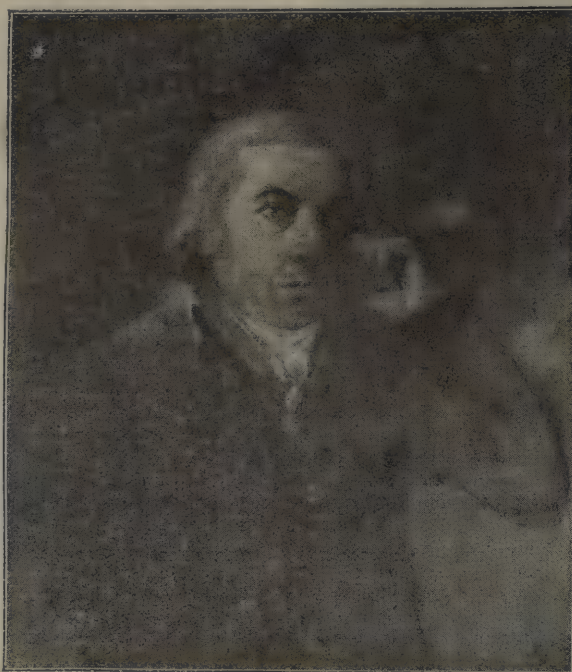
This case is brought forward on account of the indirect testimony which it furnishes of the correctness of the statement that in those cases where the ear disease has already set up a certain amount of inflammation at the base of the brain, it is not sufficient to thoroughly drain and cleanse the original seat of the disease in the ear. Something more potent is required to bring about a subsidence of the deeper-seated inflammation, and this is to be found, I believe, in the counter-irritation furnished by the usual mastoid operation. In direct confirmation of this belief, I will give the details of a second case in which the local conditions of disease in the ear were very much the same as those noted in Case I., while the evidences of intracranial disease, at the time of the operation, were more pronounced. In fact there was already well-marked paralysis on the opposite side of the body, and yet the patient recovered.

CASE II.—The patient, a man twenty-two years of age, and of good general health, consulted me at my office, on January 7, 1893, on account of long-standing trouble in the left ear. He gave the following history: There had been a discharge from the left ear since childhood, and on several occasions he had experienced pain in the ear, lasting perhaps for two or three days, and then passing off. The last of these attacks had occurred during the previous November, and had been of unusual severity. From that time to the present he had experienced a great deal of dizziness, and at times he had felt decidedly chilly, without having, however, a distinct chill. At other times he had felt feverish. The discharge, during this period, had remained unchanged in quantity, but from time to time he had found it streaked with blood. His general health had

deteriorated appreciably during this period, and he had lost flesh to the extent of twenty pounds. Quite recently there had developed a new symptom which had given his family some alarm. I refer to the sensation observed on the right side of walking on cushions. His gait, too, had become somewhat unsteady, through his inability to perfectly control the motions of the right leg.

When the patient called at my office, I observed that he dragged the right leg a little, and that he presented the facial aspect of one who was seriously ill. An examination of the ear revealed the existence of a large polypoid mass which nearly filled the left external auditory canal. After it had been removed, it was found that an opening into the tympanic cavity existed in the vicinity of Shrapnell's membrane. A slender probe was introduced, but no exposed bone was encountered. Hyperostosis of the inner half of the external auditory canal concealed a large part of the drum membrane. The odour of the discharge coming through the sinus was very offensive. There was no tenderness or redness at any point in the immediate neighbourhood of the ear. Mastoid operation advised.

On January 10th, three days later, I found the patient, at his home in the country, materially worse. There was a moderate elevation of temperature (about 101.5° F.), and his pulse varied from 100 to 110 beats per minute, being at the



EDWARD JENNER.

(From an Oil Painting now exhibited at Bristol. Specially photographed for "Medical Reprints.")

same time quite weak. He had scarcely any power over the movements of the right leg, and he expressed himself as feeling very ill. Shortly afterward he had a distinct chill.

Ether was administered and the operation of opening into the mastoid antrum was performed in the usual manner. The bone was found to be everywhere of ivory-like consistence, requiring considerable force of the mallet to drive the chisel through it. Volkmann's spoons proved to be of no use until the antrum had actually been reached. They were then used in enlarging the opening into this cavity. By repeated injections of a warm 1 to 4,000 bichloride of mercury solution, and by the frequent employment of the slender middle-ear probe, which was pushed as far as possible in all directions, the cavities of the middle ear were finally cleared of their foul cheesy contents. It was surprising how large a quantity of this material was stowed away in this comparatively small space. A careful exploration was made for the purpose of ascertaining whether, through destructive ulceration, an opening had not been established in the bony tegmen tympani. No such opening, however, could be found.

The edges of the wound were left gaping, iodoform gauze-dressings were applied, and daily cleansing of the parts constituted the essential feature of the after-treatment. The patient was under the care of Dr. T. H. Andress, of Sparta, New Jersey. About the fifth or sixth day, when it was found that the case was progressing favourably in every respect, the edges of the granulating wound were approximated by means of a silver suture, which had been put in place (ready to be utilised at some later date) at the time of the operation. On February 16th, five weeks after the operation, the patient called to see me at my office. The external wound had entirely healed, but there was still a very slight discharge from the external auditory canal. All pain in the ear and head had disappeared, and the right leg had returned to an entirely normal condition. His general health was excellent.

In the following case, thanks to an error which I made in the diagnosis, I am warranted in excluding wholly from consideration the possible effects of drainage and cleansing upon the favourable course pursued by the obscure deeper-lying disease. Absolutely no ear disease whatever was found to exist in this case at the time of the operation, and, consequently, in weighing the therapeutic effects of the latter, we are perfectly justified in speaking of it as an issue pure and simple. The history of the case is as follows:

CASE III.—The patient, a lady about fifty years of age, and, up to the time of the attack, in good general health, contracted a bad cold in the head early in April, 1892. This was soon followed by tinnitus and pain in the left ear and impairment of the hearing. The pain resisted the ordinary measures employed for its relief, and gradually increased in severity. It involved the entire left side of the head, but was referred more particularly to the mastoid region. When the patient was seen by Dr. Thomas E. Satterthwaite, about May 1st, he found decided swelling and tenderness of the auricle and neighbouring soft parts; the motions of the jaw caused pain in the left ear; the glands on the side of the neck, below the left ear, were swollen; and there was a tense swelling on the posterior wall of the pharynx, behind the left tonsil. An incision of this swelling afforded escapes to a considerable quantity of creamy pus. The posterior wall of the left external auditory canal was found to be swollen, and an incision in this region also gave vent to a certain amount of pus. From this time onward, for a period of nearly three weeks, the patient experienced comparatively little pain in the ear or in any part of the head. The hearing on the left side soon returned to a fairly normal condition. Pus, however, continued to escape from the opening in the posterior pharyngeal wall, and the patient steadily grew weaker. The constant escape of pus into the fauces rendered her less and less desirous to take food. In fact, she had to be coaxed a great deal before she could be induced to take the necessary

amount of nourishment. It was observed, too, that her mind was beginning to be perceptibly affected, and the pupil of the left eye was noticeably larger than that of the right. The body-temperature did not at any time during her illness rise above 99.5° F. The pulse-rate was about 80, and the pulsations, as might be expected, were feeble. About May 20th she was seen by Dr. Robert Abbe. He was disposed to refer the source of the pus, which continued to flow abundantly from the opening in the pharyngeal wall, to disease of the sphenoid bone. He advised against operative interference. Shortly after this, the patient again began to complain of pain in the left mastoid region, and it was found that the hearing of the left ear had again become somewhat affected. There was also some redness of the skin behind the left ear, together with slight tenderness on pressure. As these symptoms persisted, I was asked (May 26th) to see the case, in consultation with Dr. Satterthwaite and Dr. Terhune. I found the patient in a condition of semistupor; whether from simple physical weakness or not I could not determine. Her pulse was 80, and decidedly weak. There seemed to be some redness and swelling of the left mastoid integuments; but as a blister had been applied over the lower part of the process, and some distance below it, two or three days previously, I could not feel sure of the correctness of my observation. The external auditory canal and the membrani tympani were entirely free from any evidence whatsoever of inflammatory action. The spitting-cup, filled with water, was shown to me, and in it, floating as a separate mass, was about a tablespoonful of thick yellow pus. This represented, I was told, the entire quantity that the patient had spat out during the previous twenty-four hours. An examination of the pharynx revealed no points of special interest. The exact spot from which the pus escaped could not be verified by mere ocular inspection.

In the presence of such conflicting evidence—a history pointing strongly to the left ear as the primary seat of all the trouble, and yet, at the time of my examination, an almost entire absence of any recognisable disturbance in that ear—I felt considerable hesitation about putting forward even a diagnosis of probabilities. Nevertheless, from the sequence of pathological events, and especially from the recent return of

mastoid pain and tenderness, I felt disposed to believe that there was still, in the substance of the mastoid process, a small remaining centre of osteitis, the purulent products of which were escaping through some opening in the under part of the process, presumably in the vicinity of the digastric fossa, and were seeking an outlet through the unhealed opening made in the post-pharyngeal abscess. This centre, I assumed, must necessarily be somewhat removed from the mastoid antrum, and from that part of the process which constitutes the posterior wall of the external auditory canal; for, otherwise, it would have betrayed its existence by redness or swelling of the soft parts of the canal—both of which conditions (as already stated) were absent. I further argued that if, perchance, this diagnosis should prove to be correct, the more direct drainage and ultimate healing of the centre of the mastoid inflammation which we might reasonably expect to obtain by an operation, would, in all probability, cause the post-pharyngeal abscess to heal.

On the following day, May 27th, the operation was performed. A curved incision, about two and a half inches in length, was made through the skin and periosteum, the outer surface of the mastoid bone was freely exposed, and by means of the chisel and mallet and Volkmann's spoons, a large part of the bone substance lying external to the antrum was removed. Not a trace of anything like diseased bone was found either in the main body of the bony prominence or in the direction of its tip, a large part of which was removed with the Volkmann's spoons. There was not even any recognisable congestion of these parts. In a word, the mastoid was found to be in a perfectly healthy condition.

The edges of the wound were left gaping, and simple iodo-



Original Drawing for Dr. Jenner's work, entitled:

"AN INQUIRY."

form gauze dressings were applied. From this time forward the patient, who remained under the care of her regular attendant at first, and then for a brief period under that of my associate, Dr. Robert Lewis, improved steadily though not rapidly. In the course of from four to five weeks the outside wound had healed, the discharge from the post-pharyngeal abscess had ceased, the mental disturbance had disappeared, and she had fully regained her general health and strength.

By way of summing up, let me rehearse briefly the salient distinguishing features of the foregoing three cases. In the first two it is highly probable that the intracranial lesions were very nearly alike in extent and intensity. In the one the original centre of carious bone, with its accumulation of foul *débris*, was effectually cleansed and drained, and yet the intracranial disease pursued its course to a fatal termination without manifesting any but a transient tendency to quiet down under the influence of this drainage and cleansing. It had acquired so great an independent momentum that it no longer needed, for a continuance of its harmful course, the stimulus of the adjacent centre of middle-ear disease. The same remarks, I believe, apply with equal correctness to the second case. Here, too, the original centre of carious bone disease in the middle ear was drained and cleansed, but the intracranial disease, instead of growing worse, underwent a steady and permanent change for the better. To what shall we attribute this favourable change if not to the powerful counter-irritant effect furnished by the presence of an extensive issue in the immediate neighbourhood?

Finally, in the third case, the conditions of our problem in therapeutics are rendered peculiarly simple by the entire absence, so far as could be ascertained, of any centre of disease in the middle ear or mastoid bone. In this case, therefore, the establishment of an issue pure and simple is the only therapeutic procedure of which there can be any question. Indisputable, too, is the existence of some deep-seated and serious disease; whether at the base of the brain, or in the sphenoid bone, or where, is just now a matter of no special importance. The patient's full and, on the whole, rather quick recovery completes the series of facts. Do they not warrant the conclusion that counter-irritation, in the form of an extensive issue, effected the cure obtained in this case?

OSTEOMA OF THE ORBIT.

By FRANK N. LEWIS, M.A., M.D.

[A paper read before the New York State Medical Society.]

COMPARATIVELY few cases of osteoma of the orbit have been reported, and the subject, as far as I can learn, has received little attention, either in the text-books or in the journals. Probably this is due to the fact that the disease is of somewhat rare occurrence. Dr. J. A. Andrews, in the *New York Medical Record*, September 3, 1887, has a paper on this subject, in which he describes two cases of his own and also reviews the literature up to that time. Since then Dr. Pooey¹ has reported a case where he successfully removed a large osteoma. Dr. Knapp² has also reported a case, and others are described by Grossman,³ Jones,⁴ Adamik,⁵ and Watson.⁶ These cases have shown much variation as to size, location, and the facility with which the growth has been removed. The consistency also has shown much variation, from rather soft bone to that of a hard ivory character. In some of the cases there has been a distinct narrow pedicle springing from either the frontal, ethmoid, or superior maxillary bone, while in other cases the attachment has been broad and firm. As to the etiology, it has not been shown in all cases to be very clear. Traumatism, no doubt, has been an important factor, either as a primary cause or as an exciting cause of more rapid development of an already existing osteoma.

The case which I desire to report here came under my care at the Manhattan Eye and Ear Hospital, and through the kindness of Dr. Roosa I was permitted to operate for the removal of the growth.

Andrew P—, twenty-seven years of age, a blacksmith's helper, was admitted to the Manhattan Eye and Ear Hospital on May 10, 1892. The patient was fairly well and strong, and

stated that he had always been in good health. There was no history or indication of syphilis or other disease. He stated that about eighteen months before, his wife had noticed that the right eye seemed to be more prominent than the left. Two months before this, the patient was struck by a stone on the right mastoid process. The wound healed quickly, and there had been no trouble at this point since. A few days before the protrusion of the right eye was first noticed, he had been bitten on the bridge of the nose by a dog. This wound also healed quickly and had given him no further trouble. There was a history of no other injury. The exophthalmus had gradually increased. There had been no pain, redness, or swelling of the lids or eyeball, and the vision had remained good until three months ago, when it began to fail and had gradually grown worse. No treatment of any consequence had been followed.

On admission to the hospital the condition was as follows: V. R., $\frac{2}{20}$; V. L., $\frac{2}{20}$. The right eye was pushed forward, downward, and outward. There was no redness of the lids, except that the palpebral conjunctiva was slightly redder than the left, and there was some lachrymation. The eyelids could be closed, and the motion of the eyeball was good in all directions except upward, where it was slightly limited. The cornea, lens, and vitreous were clear, and the pupil responded well to light. With the ophthalmoscope there was seen to be well-marked optic neuritis. The disc was not much swollen, and the retina was clear, and there were no hemorrhages. There seemed to be no pain or tenderness on pressure. Above and extending behind the eyeball a firm mass could be felt. It did not give the sensation of hard bone to the finger, as, from what was subsequently learned at the operation, the growth was deep in the orbit, and there was much soft tissue in front. It was decided to attempt the removal of this growth, and on May 14th, with the assistance of Dr. Roosa and Dr. Emerson, the operation was performed, ether being given. A free incision, one and one-eighth inch below the superior orbital ridge, was made, and extending from above the inner to a point outside the outer canthus. After dissecting down through the soft tissue, the hard, bony, irregular mass was reached, about one half inch behind the orbital ridge. It was firmly implanted against the superior and inner walls of the orbit, and no well-defined pedicle was to be made out. The growth was removed with the chisel, and its removal was accomplished with much difficulty. It was attached by a broad surface to the frontal and the ethmoid bones, and a point of the growth extended to, if not into, the optic foramen. On removal it was found to be of ivory hardness, irregular in shape, with smooth surface. Its weight was thirty-one grammes, or nearly one ounce. The longest diameter was 44 mm. by 24 mm. On the inferior surface was a deep groove, which probably lodged the optic nerve, and from pressure may have been the cause of the neuritis, as this groove must have nearly encircled the nerve. The cavity was thoroughly washed and some small chips of bone removed. The wound was closed with sutures, and a drainage-tube inserted. The operation was done with thorough aseptic precautions. On recovering from ether, the patient vomited blood, and there also was blood coming through the nose on the right side, showing that there was a communication between the orbital and the nasal cavities, and this was also later shown in dressing the wound, as fluid could be forced through the drainage-tube into the nose.

During the evening the dressings having become saturated with blood, they were removed. There was swelling of the lids and chemosis. On the following day, the patient having slept fairly well during the night, the dressings were reapplied. There was swelling of lids, and conjunctiva and eyeball still somewhat protruding.

On May 16th, two days after the operation, the patient was taken with vomiting during the afternoon, and at 6 p.m. the temperature was 106.3° F., and pulse 128, irregular and intermittent. There had been a chill. There was no delirium and the patient very rational, but having some pain. Wound redressed, and in washing through the drainage-tube fluid passed into the nose. Hot applications were kept constantly applied. Morphine was given hypodermically, and patient was sponged with alcohol.

From this time on the patient made a steady but slow recovery, the temperature gradually subsiding. There was much swelling and redness of the lid and destruction of the epithelium, but the deeper parts of the lid healed well. Some suppuration from the cavity in the orbit followed, but this gradually subsided. The eyeball did not become inflamed, the cornea remaining clear. The vision became much worse; two days after the operation there was only perception of light, and at the end of seven days there was no perception of

¹ Transactions of the American Ophthalmological Society, 1890.

² Archives of Ophthalmology, March, 1888.

³ Ophthalmic Review, December, 1887.

⁴ Transactions of the Ophthalmological Society of the United Kingdom, 1888.

⁵ Archives of Ophthalmology, vol. xix., 1890.

⁶ Transactions of the Ophthalmological Society of the United Kingdom, 1889-1890.

light. Nine days after the operation there was some paralysis of the left hand, the patient being unable to close the fingers, but had good use of the arm and forearm. This paralysis lasted for three days.

The swelling and redness of the lid gradually subsided, and suppuration stopped. The communication with the nose remained for two weeks.

The patient was discharged from the hospital June 27th, six weeks after the operation, and at this time the wound was well healed. The eyeball was still somewhat protruding downward and outward. There was ptosis and inability to rotate the eye upward or outward. The optic disk showed white atrophy.

The patient has been seen since, the last time was in October, four months after leaving the hospital, and at this time there was less exophthalmos, although still very apparent. There was better motion of the eyeball and lid. A small sinus at the outer angle of the wound. Patient has no pain.

REMARKS.—Some points about this case are worthy of consideration. As to the cause of the growth, the patient gave a history of two injuries, one on the right mastoid two months before the exophthalmus was first noticed, and the other, a bite on the nose by a dog, about the time the exophthalmus appeared. It is doubtful to my mind whether either of these injuries was more than an exciting cause of increased development of an already existing osteoma. The size of the growth is also an interesting feature. From the displacement of the eyeball previous to the operation it was hardly to be expected that the growth had attained the size which it had. On placing the mass in the orbit of a normal adult skull, it more than filled the cavity. In its original position it had involved the ethmoid, and was pushing its way into the nasal cavity, a free communication between the orbit and the nose following the operation. The danger of meningitis, which has followed in some of the cases reported, was kept in mind. As the tumour extended well into the optic foramen, and as the ivory hardness and firm, extensive attachment rendered necessary considerable traumatism in the removal, this danger was rather increased. No well-marked symptoms of meningitis did appear. A slight paralysis of the left hand occurred nine days after the operation, and it may be doubtful whether this was from meningeal or cerebral trouble. The rise of temperature to 106°3' F. on the second day made the outlook for recovery doubtful. No antipyretic medicines were employed other than sponging with alcohol, hot applications to the eyelids, and morphine to relieve the pain. The nutrition of the patient was carefully attended to, and this probably had much to do with his recovery. The optic atrophy which followed was chiefly from traumatism at the operation; but as there was already, before the operation, optic neuritis, atrophy would have been expected had no operation been done.

OUR ILLUSTRATIONS.

THE JENNER COLLECTION AT THE BRISTOL INDUSTRIAL AND FINE ART EXHIBITION, 1893.

THE notice of the John Hunter Centenary in our last issue may be fittingly followed by one of his pupil and intimate friend, Dr. Edward Jenner. These, with Harvey, make up the mighty trinity of English medical worthies.

Jenner was born May 17th, 1749, at Berkeley, Gloucestershire, was apprenticed, after receiving a sufficient education, at Sodbury, studied under John Hunter at St. George's Hospital, and resided with him as his disciple, aid, and friend. Jenner returned to his native place in 1773, and commenced to practise as a surgeon. It was from John Hunter that he acquired a skill in making anatomical preparations worthy of such a master. In 1792 he became M.D. of St. Andrew's University, and confined himself thenceforward to medicine. When at Sodbury he had learned that those who had contracted cow-pox from milking cows considered themselves practically proof against the generally prevalent small-pox, and became imbued with the idea which subsequently developed into his immortal discovery. Now, having time and leisure to prosecute his investigations and experiments, he developed by degrees the masterly chain of reasoned demonstration which was so soon to make his name famous through all time. Nevertheless, he found it very difficult at first to obtain acceptance from his London friends—even Hunter laughed at him. But it is hard to tread down a stubborn inventor or discoverer, more especially if he have means behind him, which was, fortunately, Jenner's case. His small private fortune sufficed

him to prosecute his hobby, and to meet the inevitable expense of investigation. His deductions were published as the "Inquiry into the Causes and Effects of Variolæ Vaccinæ." The results of this work and of his subsequent efforts to obtain recognition of his discovery were so successful that by 1799 all, or most, of the leading physicians of London had signed a declaration of unreserved concurrence in his views and practice.

The practice now became rapidly established everywhere. The "Relics" which we are about to describe attest this. Every inducement was offered to him to establish himself in London, and become a "great physician." But it was not in his nature to accept such conditions. He preferred the lowlier path.

There is enough in the Bristol collection of Jenner relics to fill a small museum, but the authorities could only grant so much space as we see the relics displayed in. Let us contrive to tell as briefly as possible in what these consist.

There are oil portraits of the Jenner family—the progenitors—five in number, of the family portrait type, in the Kneller manner. Then comes an oil portrait of Dr. Edward Jenner himself. This, which is half length, tells its own story. It need merely be said that the complexion is florid, the whole appearance that of a hearty, vigorous bourgeois. There are various other engraved portraits.

The medical officers of the British Navy were the first to recognise the value of his discovery. There is in the collection an engraving of the medal presented to Jenner by Dr. Trotter and forty-four medical officers of the Navy, with an address, February 20th, 1801. Dates are vastly important when we want to consider the growth of the discovery, the rapidity with which, once accepted, it was spread, and the unanimous, the incontrovertible, testimony addressed from all quarters as to its efficacy.

In a glass case are a few of the doctor's personal belongings. An ivory statuette—a little gem—of Napoleon represents him as seated a-straddle a rush-bottomed chair, with a field-glass in his hand, his arms folded across the back of the chair. The great Destroyer and the great Preserver had a mutual respect. During the war, many English were prisoners at Verdun and elsewhere. Jenner, when asked, used to petition for an order of release. It was always granted to him—at different times by the First Consul, the King, the Emperor. On one occasion the petition was handed into the carriage. Napoleon petulantly threw it aside; but Josephine opening it, said: "From Jenner." "Ah, de Jenner!" exclaimed the Corsican, as he hastily perused the lines; "on ne peut rien refuser à cet homme!" Jenner's discovery, which restored the British forces to a position of efficiency, had also rendered a like service to those of France. How strangely do extremes meet!

Other personal objects are: a silver caudle-cap, dated 168; silver seal-top spoons, tea taster, bronze candle-snuffers of antique design, a snuff-box (made out of the wood of a mulberry tree that grew in Jenner's garden at Chantry Cottage, Berkeley), an antique, Venetian glass goblet, and another snuff-box of tortoise-shell, inlaid with gold and ivory.

One of his visiting books, with entries of many distinguished patients and significant prescriptions, and a card with seven ivory vaccine points, apparently charged with matter, are also shown—the points inscribed in Jenner's clear elegant hand: "July 7th, 1821," just eighteen months before his death. This is indeed a trace of a vanished hand, linking it in one with his discovery.

We reproduce also a facsimile of the drawing by E. Pearce, afterwards engraved by W. Skelton, for the "Inquiry, &c., &c.," of the arm of Hannah Excell, eighth day, showing the position and development of the pustule. It was with matter taken from this arm that Jenner vaccinated his second son, Robert Fitzhardinge Jenner, at the age of eleven months.

(To be concluded.)

GALLERY OF MEDICAL PORTRAITS.—XXIII.

We present in this issue the portrait of

DR. ROBERT AMBROSE, B.A., Q.U.I., L.R.C.P. Edin., L.R.C.S. Edin., &c., who was in August elected to fill the vacancy in the Parliamentary representation of West Mayo, was born at Limerick forty-five years ago. He was educated at Queen's College, Cork, and is also a graduate of Edinburgh, where he took the L.R.C.P. and L.R.C.S. For the past ten years he has been practising in London. He is a cousin of Dr. D. Ambrose, the member for South Louth, and is, of course, a member of the Nationalist party.

THE BRITISH MEDICAL JOURNAL says:—

"We have submitted the LACTOPEPTINE to trial, and can confidently recommend it."

THE MEDICAL PRESS AND CIRCULAR says of


LACTOPEPTINE:—

"Such a formula is a desideratum, considering that the preparations of Pepsin now in use have disappointed the expectations of many practitioners."

BRAITHWAITE'S RETROSPECT says:—

"A glance at the formula of LACTOPEPTINE would convince even the most sceptical of the valuable results that must ensue through its administration. Composed of *ptyalin, pepsin, pancreatine, hydrochloric and lactic acids*, it is a combination of all the digestive agents, consequently can never be administered without giving the utmost satisfaction, for if there is a deficiency in the system of all or any of these agents LACTOPEPTINE will supply it, and thus assist in digesting the food, enabling the organs that produce these principles of digestion to rest and recuperate their relaxed energies."

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 MEDICAL REPRINTS will be sent, *post free*, to the address of any medical man for twelve months at a subscription of two shillings and sixpence per annum.

Subscriptions to be addressed to the Publisher,
46, Holborn Viaduct, London, E.C.

SINGLE COPIES will be supplied, either of current or back numbers, at threepence per copy, including postage. Several issues are out of print.

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

NOVEMBER 15th, 1893.

WHEN a medical man prescribes a certain drug or combination of drugs, his right to expect that *exactly* what he orders shall be dispensed to the patient is indisputable. And when a medical man, guided by experience and observation, orders a proprietary drug, he is grossly wronged if anything else is used, however boldly the patient may be assured that this particular something else is, not something else, but the same or an equivalent thing. A doctor has reasons and experience, such as even the most intelligent patient may be excused for not divining, which guide the prescription of a particular drug. He is wronged in his professional capacity if the patient is supplied with a substitute.

The reasons which influence a medical man prescribing a proprietary brand are sufficiently obvious to the profession. To take the example which we have particularly in view,

LACTOPEPTINE, a combination of digestive ferments, has a constant formula, well known to all medical men, who have, as their continued use and commendation of it show, satisfied themselves as to its usefulness and uniform value. Pepsin preparations are the most difficult in the world to rely upon, and the profession, having experience of the trustworthiness and activity of the ingredients of LACTOPEPTINE, and knowing the unremitting care and skill with which it is compounded and its uniform activity maintained, find it more convenient to prescribe this well established combination of digestives, than to allow any mixture to be dispensed that may come to hand, and that may, for all that is known, have been compounded by a pork butcher.

Nevertheless, an attempt has lately been made, taking advantage of the free publication of the LACTOPEPTINE formula, to place upon the market an imitative compound. In order that this danger may be avoided, medical men are asked, whenever possible, to direct patients to obtain LACTOPEPTINE in the original one-ounce bottles in pink and white wrappers. The wrapping of the bottle supplied to the public contains no reading matter to which objection can be raised; but, as LACTOPEPTINE is often prescribed in combination, prescribers will in that case protect their patients by adding the name of the maker, thus: LACTOPEPTINE (RICHARDS). Of course, the name LACTOPEPTINE should be sufficient, for anything from any other quarter professing to be LACTOPEPTINE is a pure fraud; but the use of the name as above shown is an additional precaution which is worth observing just now. Medical men who receive circulars touting for the sale of substitutes will confer a favour by posting them to the Editor of this journal.

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NEWS AND NOTES.

A YOUNG lady in American Society has devised a novel entertainment, which is shortly to be made public. She calls it "The Insomnia Party," and it is to be a "reception for people who can't sleep at night." Among her friends, she says, are a great many very delightful people who are troubled with insomnia, and who confess that they spend many frightful, wakeful hours in walking the floor, looking out of the window, rocking in easy-chairs, trying to read or write, and other useless and tiresome occupations. When her plans are fully matured, this original young woman intends, on at least two nights in every week, to be "at home" to those distressed female friends from midnight until morning. The guests are requested to appear in any "unique," (*sic*) respectable bedroom gown, bath robes not excluded; the lights are to be dim, soothing music and stupid conversation will be the only diversions permitted, hot chocolate and light wafers will be served, couches and easy-chairs will be provided in abundance, and the insomnia-victims are earnestly desired to fall asleep as soon as possible. It is whispered that prizes will be offered for the first snore, but this detail is not authentically announced. The reception is to be a fact, however, and an eager expectancy as to invitations is said to be in the air.

THE swallowing of a clinical thermometer by an insane patient at Besançon, recently, was not without its usefulness. The thermometer, a self-registering one, was entirely of glass, and 113 mm. long. No disturbance was noticed, and nine days later it was passed at the anus. The scale registered a maximum temperature of 38.7 deg. Centigrade, but a subsequent verification of the instrument reduced this to 38.1 deg. The axillary temperature, which had been taken twice a day during the passage of the thermometer, was never higher than 37.2 deg. Centigrade.

A LAD, thirteen years of age, in the State of New Jersey, U.S., who was born with twelve fingers and fourteen toes, was recently relieved of the extra members at the local hospital. It is stated that this superfluity of fingers and toes is a hereditary characteristic on the maternal side, running back for several generations, and that among the family relics is a bottle of alcohol in which are preserved a number of fingers and toes removed from various ancestors, a charming piece of *bric-à-brac*.

A CORRESPONDENT of an American contemporary, *The Medical News*, calls attention to the unpleasant fact (described with much literary taste as the "Increase of the Itch") that scabies is increasing in frequency in America. The disease, says this communication, "has increased in frequency from 0.9 per cent. of all skin cases, in 1890, to 5.39 per cent. in 1891." It is most prevalent, apparently, in Philadelphia, "a town whose increasing motor restlessness of late years may be in a measure accounted for by this interesting dermatological fact." This is apparently a local witticism, whose purport eludes the European intellect. After Philadelphia come Boston (7.38 per cent.), New York (6.36 per cent.), Baltimore (4.61 per cent.), Chicago (3.53 per cent.), and St. Louis (2.88 per cent.). Evidently the *acarus* is following the star of Empire westward but slowly. It must be humiliating to Chicago, the city of the World's Fair, to find itself so near the foot of the list. The increase of scabies is attributed to unclean immigration.

SOME statistics as to the prevalence of morphinomania in France, recently published by M. Lacassagne, purport to show that the destructive habit finds a large proportion of its victims among members of the medical profession. Of 545 morphinomaniacs as to whom this writer was able to procure information, 289 (*sic*) were doctors. "It is well known," he adds—but may there not be perhaps a little national feeling in this—"that several of the most distinguished men of the profession in Germany who have died in recent years were devotees of the fatal drug."

DR. FILIPOVITCH, of Odessa, thinks he has discovered a

diagnostic sign of typhoid fever that may prove serviceable in cases where at first the usual pathognomonic symptoms are wanting. It is a peculiar callous look, and an orange-yellow or saffron-yellow hue, of all the prominent parts of the palms of the hands and the soles of the feet—parts of which, as is well known, are more or less rosy in health and became bluish in cases of cyanosis. The phenomenon is explained by the enfeebled action of the heart, a diminished amount of blood in the capillaries, and the dryness of the skin. He has observed it in every case seen by him during the last two great epidemics of typhoid fever in Odessa, and his observation is confirmed by another Russian physician, Dr. Skibnevsky. The sign disappears as soon as convalescence begins.

Dr. Filipovitch's article appears in *The Revue Médicale* for August 20th, and an abstract of it is given in *Lyon Médicale* for September 10th.

AN advertisement, it is said, recently appeared in a New York daily offering £1,000 to any man who would submit to an experimental surgical operation involving some risk. One hundred and forty-two answers are stated to have been received. A medical contemporary reports that two physicians in Ecuador are the advertisers, and that they wish to establish a gastric fistula, and repeat the observations made by Beaumont on St. Martin.

ONYCHOPHAGY (*ὄνυξ*, gen. *ὄνυχος*, and *φάγω*) is the name given by a French physician to the morbid habit of nail-biting. He finds it very common among French schoolgirls—61 out of 207 in one school. Are the deformed finger-ends and nails so commonly seen in France a result of the custom?



DR. ROBERT AMBROSE.

AMERICAN OPINION.

ENTERALGIA OF INFANTS.

By J. B. JOHNSON, M.D.

[From the SOUTHERN CLINIC.]

ENTERALGIA, or colic, of infants, is most common between the first and fourth months of infantile life, and is not only a cause of great distress and fatigue to the mother, but of much pain and suffering to the infant. Usually the infant has one attack in twenty-four hours, and the attack may recur at regular periods, either in the morning or in the evening, and may vary not only in duration, but in severity. The attacks are always sudden and the infant, while apparently comfortable, will suddenly utter sharp, piercing screams, which continue for twenty minutes, or perhaps an hour, and are then interrupted by a few moments of ease, only to have all the symptoms of colic return with increased pain and distress. The efforts of the mother to soothe or calm her babe are of no avail; the babe continues to cry and scream; it will take the breast for a minute, and then quickly let it go, and will throw itself violently back upon its mother's arm, and continue its distressing and piercing cries until everyone about the nursery becomes nervous, and anxious to do something to relieve the little sufferer. During a paroxysm the infant will rapidly draw up its legs and knees, then as rapidly extend them, and if the hand of the mother or nurse is placed upon the abdomen, it will be found to be swollen, hard, and knotted; and gas can be heard moving about in the intestines. Passage of this gas, either by the mouth or anus, is usually a sign for an abatement of the paroxysm. Generally the hands and feet become cold, and drops of cold perspiration break out upon the face. The bowels are sometimes constipated, but most frequently they are loose, and the evacuations present a thin and frothy appearance. The face often indicates by its expression the severe suffering of the babe, and is either pale or flushed. While these distressing symptoms always end without serious injury to the babe's general health, they occur and recur regularly at about the same time every day for weeks, and sometimes months; and in order to mitigate the suffering, the mother or nurse usually gives the babe stimulating potions or opiates. As a rule I have regarded these attacks as pure colic, arising from altered or vitiated secretions of the intestinal canal, but cases are now and then met with which are neuralgic, and the distinction which I make between colic or

enteralgia and neuralgia in infants consists in the symptoms. In infantile neuralgia of the bowels there is no escape of gas, the bowels are not distended or the secretions altered, and the abdomen is not distended with gas or flatulence.

Treatment.—Nothing affords a mother more delight than to have prescribed for her babe something that will relieve and cure these terrible attacks. If of a purely neuralgic character, these attacks can be not only cured, but prevented by the administration of cinchona, or some suitable form of one of its various preparations, but when the attacks are colic or enteralgia, I rely for its cure upon a mixture of equal portions of Lactopeptine and subnitrate of bismuth. During the first month of infantile life I usually give a half grain each of Lactopeptine and subnitrate of bismuth every hour during the attacks. I direct the mother to place the powder made of this combination upon the babe's tongue every hour, and continue it whenever the child is awake until the recurrence of the colic is entirely prevented. After the first month I give two grains each of the Lactopeptine and bismuth every hour. I commence this treatment during the attacks, and after a few doses the babe soon gets quiet and goes to sleep. I instruct the mother or nurse to persevere in the administration of these powders, and in a few days she will be rewarded by the pleasure of finding that her babe escapes the daily attacks of terrible colic.

A CASE OF COMPLETE GLOTTIC SPASM IN AN ADULT, FOLLOWED BY UNCONSCIOUSNESS AND PROLONGED DROWSINESS.

[Read before the American Laryngological Association at its Fifteenth Annual Progress.]

By W. PEYRE PORCHER, M.D., Lecturer on Laryngology and Rhinology in the Charleston Medical School; Visiting Laryngologist to the Charleston City Hospital, Charleston, U.S., &c.

As I have been able to find records of only twenty-seven cases of complete glottic spasm in adults, and on account of marked implication of the brain centres as shown by torpidity of bowels, persistent drowsiness, and other symptoms, which are novel, at least to the writer, I have ventured to make the following brief report of this case:—

The patient was a maiden lady, aged fifty-two years, at the menopause. She was brought to my office for the removal of large tonsils on account of difficult respiration at night, with frequent terrifying nightmares. She attributed this condition to an attack of influenza which she had had several months before.

Since that time the paroxysm had not been severe, but her attendants stated that she would be awakened by the cough after dropping to sleep, and it was described by her as a feeling of choking or gagging in the throat. There was no dyscrasia, except such as resulted from a slight malarial cachexia. She was of a very sanguine temperament, inclined to plethora, and so nervous that she expressed the greatest alarm when requested to enter my dark room. She could not go into a church or other crowded place without a sense of fear and oppression.

On examination, her tonsils were found to be so small that they could not be caught in the grasp of either of two improved amygdalotomes. They were, therefore, thoroughly cauterised with the galvano-caustic knife.

She was ordered a simple antiseptic gargle and cautioned against taking any hot food, coffee, &c.

The first night after the operation she had no great pain or unusual difficulty of breathing. The next morning she attempted to drink some coffee which she said was not hot. Upon taking the first teaspoonful she complained of a peculiar giddiness and rushed to the window for air, but fell back upon the floor unconscious. The attack lasted but a short time. On my arrival soon after, she had entirely regained consciousness and was comfortable. As her attendants stated that she was very drowsy, ten grains each of calomel and soda were ordered to be taken at once. At the evening visit it was found that the medicine had not acted, and the next morning there had been but one slight evacuation. This together with the persistent drowsiness which lasted for several weeks, indicated that there was marked implication of the brain centres, although there had been no return of the attacks of insensibility.

She was ordered sulphate of strychnine, one-twentieth of a grain, with one grain each of quinine and iron. This dose was gradually increased until one-tenth of a grain of strychnine was taken three times daily. Small doses of a saline cathartic

were also given from time to time in order to keep the bowels open.

About thirteen days after the first cauterisation, the left tonsil remaining still somewhat enlarged, a second application of the galvanic electrode was made to it. This was followed by most satisfactory results. She informed me that her rest the night following had been very refreshing, without difficult respiration, pain, or nightmare.

The patient was kept under observation for about fifteen days longer. At the end of this time she expressed herself as having regained control of her nerves, and considered herself well.

On account of the well-known tendency of hot coffee to enter the larynx, and for the reason that I know of no other cause to which to attribute the sudden attack of insensibility, as there was no paralysis present, I have been inclined to regard this as a case of laryngeal vertigo or complete glottic spasm, and have so entitled it. It might be thought that the vertigo was in some way due to the menopause, but this would not account either for the prolonged stupor or the torpidity of the bowels. Cases of laryngeal vertigo have been reported, in which cough has either been absent, or not of any great severity, and others in which the nervous element was most prominent, but in which there were no attacks of absolute insensibility, and again other cases in which very slight paroxysms of cough would be followed by complete unconsciousness. The insensibility with slight cough, as in this instance, is perhaps best explained by the theory of McBride that the attack was preceded by a series of short inspirations followed by spasmodic expiration and a partially closed glottis. Here, also, the patient was not even aware that any coffee had actually entered the larynx, but was seized with a sudden gasping for breath, and, after rushing to the window, fell unconscious, as she said, "in a heap upon the floor." It is the opinion of the writer that this loss of consciousness, like aural vertigo, is a symptom of a specific disease, and should not be confused with that vertigo which results from holding the breath for a sufficient length of time, or even that which results from a severe paroxysm of cough or sneezing. It should not, in any respect, be regarded as an epilepsy, as there was never any spasm or jerking of any description at the incipency or at any time during the attack.

TONGUE TRACTION IN ASPHYXIA NEONATORUM.

By CHAS. G. AMENDE, M.D.

THE fact that there has been considerable discussion in some medical journals upon this subject will be my excuse for referring to the following modification of the original Esmarch treatment. The infant is placed upon its side or belly, and while the thumb of the left hand of the operator rests under the chin, the index finger upon the tongue at the root, the right hand is placed upon the chest. Then the chin and tongue are drawn forward in alternation with compression of the chest.

In a case last winter the first traction was followed by a sound like a smack, attributed to a loosening of the epiglottis, previously agglutinated, as it probably always is during intrauterine life. A full cry followed a few more tractions.

NOTES OF FOUR CASES OF UTERINE DISORDER CURED.

By JAMES MITCHELL, M.B., L.R.C.S.E. and L.M.,
Late Surgeon, R.N.

[An Original Article specially written for MEDICAL REPRINTS.]

CASE I.—C. M.—, a young anæmic female farm servant, unmarried, æt. twenty-nine, consulted me on the end of last month. She suffered at the expiration of every three weeks from a stinging, grinding sense of fulness in and around the uterus, with great down-bearing pressure, as if something "was giving way." This state of matters continued until she could suffer no longer, having been trying the usual remedies recommended by gossiping neighbours, quack remedies, &c., such as pills, savine, turpentine, and a host of other nostrums. At last, being forced to seek professional assistance, she had recourse to a local medical man, who gave her very little encouragement. He at once put her on the ergot, steel, and quinine treatment, and told her to go on steadily with them. After over a month's trial of said remedies, matters still

remained in *statu quo*, and she became quite disheartened, hysterical, and very excited, and only the other day her relations came over to me to see if really anything could be done, and asked me to visit her. I went and visited her, finding her in a very pitiable condition, and put the usual questions as well as making an examination *per vagina*. The uterus I found was very rigid, and inclined to swerve to the right, with very great pain on pressure, markedly worse on sitting. Having carefully considered the symptoms, I ordered a uterine stay bandage for support, pil. opii. grs. iss. statum, and prescribed Elixir Caulocorea treatment, ʒij. ter. die, with pil. carb. ferri, and have since learned, after a lapse of a fortnight, that she is now in her usual health and able to follow her avocation, which I have no doubt was attributable to the efficacy of the Elixir Caulocorea administered.

CASE II.—M. G.—, general servant, married, October 26th, was taken acutely ill on the beginning of last month. *Æt.* forty-six, and labouring from Leucorrhœa for nearly three or more years off and on. Excessive tea drinking of a wretched quality, drunk here at all hours, infused for weeks same tea and pot, and acts the opposite of tannin, then reducing her to a mere shadow, she lay in bed in great agony, taking enormous doses of steel (a panacea here for all those uterine complaints) till she was nearly moribund, and having been sent for in a great hurry a few weeks ago, I found her in a state of collapse. Having examined her (*per vagina*), and found it to be covered with a slimy, gelatinous, glutinous discharge, the walls of the uterus flabby and greasy, and the Leucorrhœal discharge oozing away from her. I at once ordered some stimulants, as the pulse was then only 36 or 38. Wine port ʒij. statum, beef tea, half teacup, Liebig's, given every hour, and wine every two or three hours, with gtt. iix. spir. arom., arom. vagina to be well sponged out with weak carbolic spray. The next morning visited, had a comfortable night, slept well, free from pain but still discharging a good deal but moderating. Gave her one large dose, ʒij., of Elixir Caulocorea, with ʒss. dyalegio tinct. ferri, and left half dozen of pil. opii, grain each, ordering one at bed time, along with another dose of the Caulocorea, ʒss. I then left her for the night, saw her again next forenoon, and certainly a very marked state of improvement then presented itself. I found her sitting at the fireside, although very weak, but freely and candidly admits that it was the "stuff I brought" with me (meaning the Elixir Caulocorea) that "bettered" her (using a Shetland expression), and very very grateful she seems to me, and to all, for the prompt relief she obtained from my hands by my early and timely visitation. She is now at work knitting, spinning, carrying peat, &c.

CASE III.—Jane S. Crofter, nineteen, suffering from painful Dysmenorrhœa for the two past months, unmarried, of a weak anæmic build, disappointed in marriage, slight cerebral symptoms, displayed at intervals, had a miscarriage last year, and it so unhinged her mind that she threatened self-destruction, but since then has rather improved in mental organisation, but woefully distressed with her painful catamenial attacks nearly every month. Has got tired of asking anybody's advice; takes no heed, goes on suffering, as she says she gets no sympathy; what is the use of trying this and that, it will do no good. At last it came to such a crisis, hysterical mania, that the neighbours had to at once send for me, a few weeks ago, to try and relieve her. Having seen her and also examined her *per vagina*, I found the uterus, walls, vagina, and the

whole appendages in a state of intense rigidity from the excess of steel taken, conjoined with twenty-four hours infused theine decoction. I at once gave her a gr. ij. pil. opii to allay rigidity, feet bathed in Ol Tereb, ʒss. to aq. bul. Cing. 1, and hot water; told her to desist from "tea," drinking and steel, and ordered porter and a little wine or Liebig, &c.; gave her before leaving three teaspoonfuls of Elixir Caulocorea, of which I left a bottle, ʒiv., with her, and to follow it up till I saw her again. In a little over a week she was out visiting some neighbouring girls, and then I determined not to go back without seeing her. I saw her working at a spinning-wheel, well and happy, and now enjoying very tolerable health.

CASE IV.—H. W.—, *æt.* forty-nine, Shetland dressmaker and knitter; married three years, husband sailor, died abroad; has had two miscarriages, some three years ago, and two children at full term, one of which nearly terminated her existence. Of these two, one was a case of monstrosity, the other born an imbecile, both still alive, aged eight and ten. Still suffers intensely from Leucorrhœa, dysmenorrhœa, almost amounting to complete suppression. The imbecile child preys very heavily on her mind and makes her very hysterical. Still she is perfectly rational and sensible although often incapacitated from doing any house-work, *pro tem*. Has tried everything, and

nothing seemed to give her the slightest benefit, and had it not been for a friend and well-wisher of hers living close to, and who unknown to her, called on me and asked if I would go and visit her, explaining to me her whole history, she would have been in the same condition still. I took a great interest in the case and put her on better diet, and prescribed porter with iron and quinine, &c. Left a small ʒvi. bottle of Elixir Caulocorea, giving orders for her to take three teaspoonfuls on an empty stomach, to be increased to four, three times a day; and as she is some distance off I did not again visit

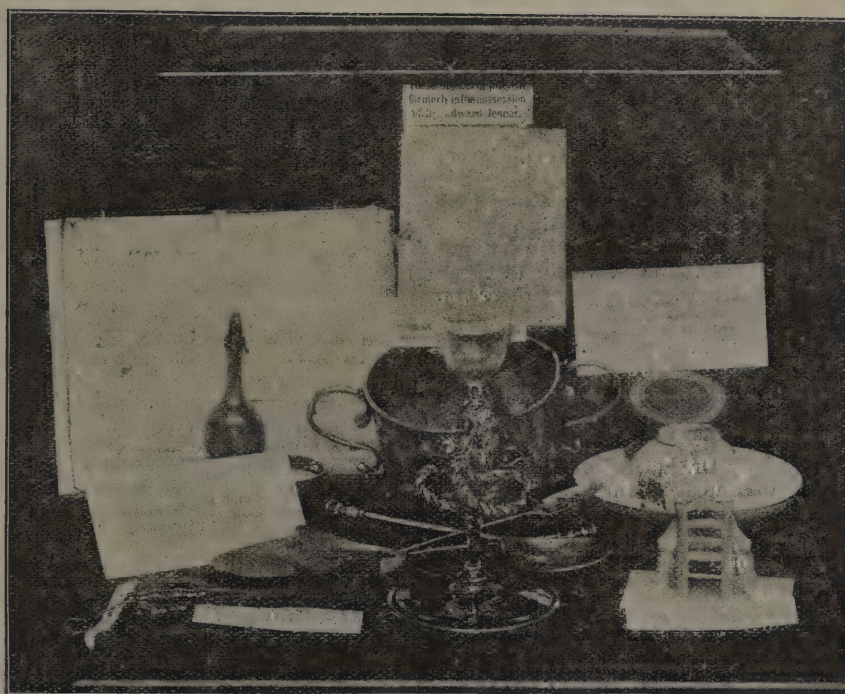
her for more than a fortnight after, when I found her up and doing, following her usual employment, in the enjoyment of better health than ever she has had for fifteen years.

These are but rough notes from a rough country, but they serve to mark the value of a treatment which might with advantage be tried by colleagues practising in more favoured localities.

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

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|--------------------------|--------------------------|
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| No. 7 (July, 1890). | No. 17 (June, 1891.) |
| No. 10 (November, 1890). | No. 19 (August, 1891). |
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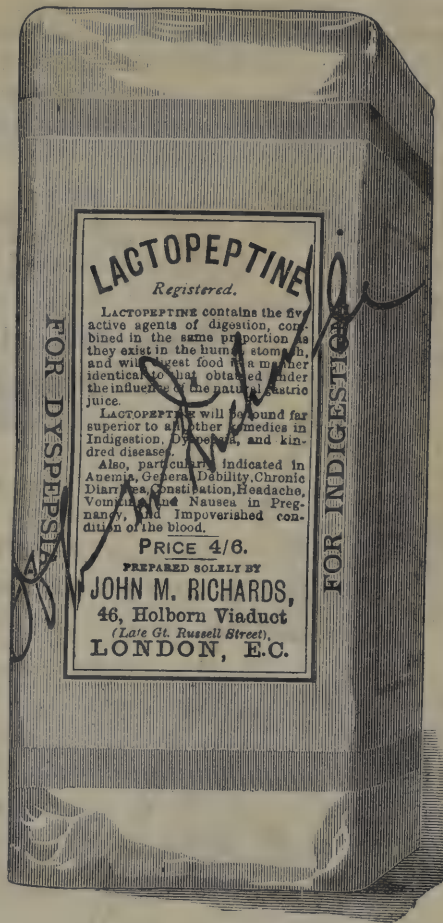
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MEDICAL REPRINTS

Home, Foreign, and Colonial: with Original Essays.

VOL. IV.]

LONDON: DECEMBER 15th, 1893.

[No. 47.

THE THERAPEUTICS AND TREATMENT OF THE URIC-ACID DIATHESIS.

By J. LINDSAY PORTEOUS, M.D., F.R.C.S. Ed.

SOME authorities state that there are no recognised symptoms of a definite kind to warrant the term "uric-acid diathesis," but this I venture to question. I will preface my remarks on this subject with the symptoms of two cases recently under my observation, and I hope to be able, in part at least, to prove that my right to question the above assertion is not wide of the mark.

CASE I.—E. F., girl, aged ten years, thin and neurotic, complains daily of frontal headache, frequent pain in region of kidneys, also of bladder. Restless at night, often grinds her teeth, has a small appetite, and is very particular about her food, and the food she prefers is of very poor nutritive quality. She is often very bright and happy, but as often dull and depressed. She easily "takes cold," and frequently has a chill, which generally precedes the symptoms above mentioned. She has a deep, hollow cough; her eyelids are at times oedematous and feet cold; has also chronic enlargement of the tonsils; very little exertion causes profuse perspiration. She is also persistently constipated. The family history reveals gout for several generations on the paternal side. An examination of the urine during these attacks shows a high specific gravity; there is an excessive acid reaction, with sometimes a trace only of albumen; at other times a considerable amount. The microscope revealed uric-acid crystals in quantity. During the attacks there was a frequent desire to micturite, and this probably is attributable to the irritation caused by the uric acid. The faces were generally of a very dark colour.

CASE II.—A typical case of a man aged thirty-five years; general appearance plethoric; subject to flushings and severe congestive headaches, described as a "fulness in head and like to burst." At other times the headache is like hemicranial neuralgia. There is a dark, almost black shade beneath the eyes, and sometimes on inner half of upper eyelids and sides of upper part of nose. There is slight "baginess" beneath the eyes, and the skin there is easily pinched up, which distinguishes it from Bright's disease in this particular point. The appetite always good, but there is frequently discomfort in the epigastric region after food. Considerable flatulence, causing sharp pain in cardiac region. Constipation; faeces dark in colour; dull, aching pain in lumbar region, sometimes also in bladder. A frequent desire to micturite. Urine sometimes clear, sometimes dark and muddy. A feeling of lassitude and drowsiness relieved by active exercise. Such are the symptoms in a child and in an adult having the uric-acid diathesis.

Let us now, in brief, consider what uric acid is. It is a bibasic salt—that is, it contains two atoms of a replaceable hydrogen. The formula for it is $H_2(C_5H_2N_4O_3)$, or, more simply, H_2u . It forms three regular orders of salts—namely, neutral urates (formula M_2u), and urates or bi-urates with the formula of MHu , and quadri-urates. The neutral urates have lately been by some authorities brought prominently forward as the cause of gout. Sir William Roberts has, however, in a recent able article, disproved this theory in the following practical manner: He says: "The neutral urates can only be produced in the presence of caustic alkalies and in the absence of carbonic acid and the carbonates. But caustic alkalies cannot exist in the living organism, and carbonic acid and the carbonates are everywhere present. It would therefore seem impossible that the neutral urates should ever play any part in the physiological or pathological history of uric acid, and until it can be demonstrated that the salts do actually exist in the body, or at least that they can be formed under conditions which are known to be possible in the living body, it is futile to frame theories in which these compounds are made to intervene. With these remarks the neutral urates may be absolutely dismissed from our consideration as having

neither part nor lot in the vital history of uric acid, whether in health or in disease." Such remarks from such an eminent authority may be considered conclusive. Although bi-urates are known pathologically as constituents of gouty concretions, yet they are not known with certainty as physiological constituents either of the blood or urine. On the other hand, the quadri-urates are known to exist in human urine and that of birds and serpents. Roberts has proved that uric acid enters into solution in the first instance, not as neutral urates or as bi-urates, but as quadri-urates. In the healthy and those not victims to the uric acid diathesis, the normal combination of uric acid with alkaline bases maintains its integrity for some time after micturition, as well as when passing through the usual channels. If, from some cause or other, decomposition takes place in the kidney or in the bladder, the uric acid is set free and deposited in the crystalline form; hence the well-known symptoms of gravel. We must not forget, however, that all acid urines, if guarded against septic influences, deposit uric acid sooner or later. We may ask what prevents the breaking up of the quadri-urates and the deposition of uric-acid crystals within the kidney and bladder? The same authority whom I have already quoted has recently made elaborate experiments on this subject. He concludes that there are certain inhibitory ingredients in the urine which prevent the breaking up of the quadri-urates; that this inhibitory power resided partly in the crystalloids of the urine; that the chief crystalloids are urea, the chlorides, phosphates and sulphates of potassium, sodium, ammonium, calcium, and magnesium. Of these, he found that urea had no power to delay decomposition of the quadri-urates. The chlorides and sulphates, in the proportion of 1 per cent. and upwards, had considerable power. The potassium salts, however, had more effect in preventing the decomposition than salts of ammonium and sodium; but none of them approached the natural urine in its power of postponing the decomposition of the amorphous urate. He found that dipotassic phosphate, in a 0.2 per cent. solution, acted almost as slowly on the deposit as natural normal urine.

The pigments or colouring matters of urine undoubtedly have great inhibitory power. Urine that had been filtered through animal charcoal, and so deprived of its colouring matter, acted more quickly on the amorphous urate than the same urine before it was filtered.

Alkaline urine can never be the cause of gravel, nor can it cause the uncomfortable irritation of the urinary channels felt in the patient suffering from the uric-acid diathesis. We may also assert that a diminution of salines and pigments in the urine favours the precipitation of uric acid.

Seeing that in certain unhealthy conditions of the human body there is a decided tendency to precipitation of uric acid, it is of great importance to find out, as far as possible, some of the causes of the abnormal condition. We know that the children of the poor suffer far more in proportion than those of the better off from stone and uric acid. Their mode of living impoverishes the urine of its saline matters. They are fed principally on bread, gruel, and potatoes. These contain little mineral matter. They have only a small quantity of milk, meat, and fish. Now, we know that wheat flour only contains 0.51 per cent. of mineral matter, whereas meat and fish contain 5 to 5.50 per cent. of mineral matter in proportion to the totality of the dry substance. The same may be said to be the cause of so many cases of stone found among the natives of India, who live chiefly on rice. It has been shown that sailors, from the amount of salt provisions they use, are singularly free from calculus. On the other hand, we find men in easy or luxurious circumstances suffering from the uric-acid diathesis. In their urine there is no want of either pigments or salts; still they suffer, often severely. This can only be accounted for by their having an excessive quantity of uric acid secreted. The quantity in the urine bears no constant relation to the rate of

its excretion by the kidneys. The degree of acidity of the urine must exercise a power over the *time* of precipitation. The more acid, the quicker the precipitation. Knowing this, our object must be to render the urine less acid as quickly as possible. In prescribing a line of treatment, it is, according to Roberts and Garrod, very essential to differentiate between the gouty and uric-acid diatheses. Although many authors consider these complaints identical, such is undoubtedly not the case. We may find gout *alternating* with gravel in the same individual; but this does not by any means prove that they are the same disease. Uric acid appears in both diseases, but in different circumstances. In gout the trouble originates in the blood and tissues, and, according to Roberts, is deposited in a state of combination as a bi-urate. In gravel it occurs in the kidney, and is deposited in the urine in a free state. This is very necessary to know, as it may guide us in determining our line of treatment.

As we have already stated, we must endeavour, in treating this disease, to render the urine less acid as early as possible. I have also stated that it is impossible for an alkaline urine to deposit uric acid, or for a neutral or slightly acid urine to deposit it. In citrate of potassium we have a powerful agent to render the urine less acid, and, with the addition of benzoate of lithium, I have found in many cases that in from twenty-four to forty-eight hours I had neutralised the urine. But we know that gravel may last intermittently for months or even years, and we could hardly expect a patient to persist for weeks or months in taking alkaline doses. We must direct our attention to some other means, and those means must, as far as possible, be preventive, using the alkalies only on occasions where some error in diet, or some other cause, has increased the amount of uric acid.

Precipitation of uric acid may take place either in the kidneys or bladder. The results of the former are more serious than those of the latter, as any deposit in the bladder is washed out during micturition. We ask, "How are we to distinguish between the condition of the urine as it is secreted by the kidney and the urine after it has been some time in the bladder?" This is very important to know. Urine which has been in the bladder for some hours may, according to Roberts, have frequent changes from acid to alkaline, from dilute to concentrated, from richness to poverty of uric acid. To get, therefore, a correct knowledge of the urine as it passes through the kidneys the urine must be obtained and examined at short intervals. Roberts made some valuable experiments with the object of finding out a preventive treatment of urinary gravel. The following are his conclusions: That the character of the urine was most affected (1) by the digestion of food, (2) by prolonged fasting, (3) and by sleep. He found that *after* a meal, no matter of what it consisted, the acidity decreased and the amount of urine increased. Prolonged fasting, on the other hand, raised the acidity and diminished the flow of urine. During sleep, which was likewise a time of abstinence, acidity reached its maximum, and the flow of urine its minimum. The percentage of uric acid was greatest during the time of sleep, but the hourly secretion was greatest after meals. From what has been previously said, we know that the greatest risk of renal precipitation is during sleep, especially towards breakfast time.

We have seen from the foregoing that the acidity is most dangerously increased during sleep. To lessen the danger we must give some drug that will have the effect of counteracting the acidity. In my experience, I have found that a dose at bedtime, consisting of ten grains of benzoate of lithium and thirty or forty grains of citrate of potassium in half a glassful of water acts admirably. If, however, the acidity is very great, Nature steps in and makes the sleeper restless, and finally awakens him. This means that the alkalinity has again been overcome by the acidity, and another dose is necessary. Although, as we have already seen from Roberts's experiments, the urine is less acid during the day when digestion is going on, it may be necessary to give one or two doses—the same as already mentioned—during the day. If, however, for some reason this dose cannot be taken as often as might be necessary, the meals ought to be increased in frequency.

In the nocturnal enuresis of children I have found this to work admirably—viz., potash and benzoate of lithium during the day, and always something to eat at bedtime. No doubt many such cases are caused by uric acid irritating the bladder and kidneys. Our object in treating patients who have uric-acid diathesis is not so much to entirely prevent precipitation as to retard it till it reaches the bladder, when we know it will be washed out as a rule. I say as a rule, because there are those who suffer from atony of the bladder, either from chronic cystitis or paralysis, or who have enlarged prostate and

cannot entirely empty the bladder. To such patients I would not only prescribe daily and nightly doses of the alkalies mentioned, but also that the catheter be used frequently, and the bladder washed out from time to time with a weak solution of soda.

Fortunately, it is extremely rare for any patient to be troubled all the time with a tendency to precipitate uric acid. Therefore I would advise those who have suffered from it to curb their appetite, lessen the quantity of nitrogenous food taken, and use freely farinaceous substances, with salads, fruits, and garden vegetables. The subject of diet is a very difficult one, as some authorities say, "Avoid fruit, sugar, and fat"; others order fat in abundance, and no starchy articles of diet. Roberts states that the most reliable investigations prove that sugar, fat, and starchy matters have no influence on the production or secretion of uric acid. The only point of real value made out by accurate investigation is that the excretion of uric acid is diminished by lessening the albuminoid ingredients of food, and increased by the reverse.

I conclude from the foregoing remarks that the principal efforts of the physician, when he has a patient suffering from uric-acid diathesis, must be to guard against renal precipitation of uric acid. If the means suggested in this paper for that purpose be intelligently carried out, the risk of attacks of gravel and even vesical calculi may be reduced to a minimum.

A CLINICAL STUDY OF PERTUSSIS,

WITH SPECIAL REFERENCE TO THE HEART AND CIRCULATION.

By E. HELEN KNIGHT, M.D.

THE following notes were made on a series of forty cases of pertussis which were seen in a period extending over six months of the present year. The cases were first seen in the service of Dr. Koplik in the Good Samaritan Dispensary, New York, and were then visited at their homes, they reporting at intervals at the dispensary. Many of the cases did not come under observation until the spasmodic stage of the disease had set in. The more severe cases were visited once or twice a day while the severe symptoms continued. The milder cases were seen once a day or every other day. The ages of the children ranged from three weeks to ten years. In the study of the cases especial note was taken of the heart and circulation; temperature elevations—in absence of abnormal lung signs; the condition of the urine; the frequency of the paroxysms and their severity; and effects of certain modes of treatment.

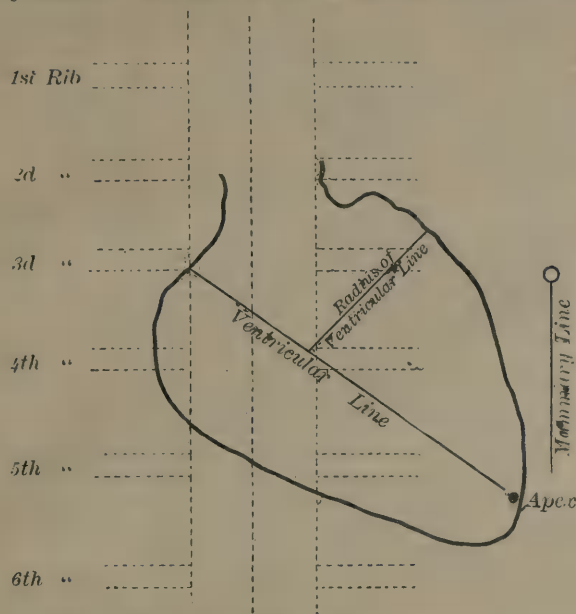
As to the heart and circulation, it is suggested by a number of observers that the heart is under a great strain *during* the paroxysms of coughing in pertussis, and that the strain is observed in the venous and arterial as well as in the capillary circulation. Also, some authors admit that it is but slowly that the heart regains itself after the paroxysm is over. Steffen (von Ziemssen, vol. vi., p. 696) remarks: "During the attack the action of the heart is essentially impeded and may momentarily cease." Also, "We must assume a transient dilatation of the heart which has an injurious effect upon its action." And again, "After the paroxysms the heart gradually regains itself and, by physical examination in the intervals, is found normal." Eichhorst states that "during the paroxysms the heart's action intermits and the pulse becomes weak." Osler remarks: "The heart stands the strain remarkably well. During the spasm the radial pulse is small, the right heart is engorged, and during and after the attack the cardiac action is very much disturbed."

We have, then, the statements that the heart does bear a strain in pertussis, it being granted by some observers that the organ only gradually recovers itself after the cessation of the spasm. In the study above referred to an effort was made to discover not only the nature of the strain during the paroxysms of pertussis, but also whether such strain *persisted* in the *intervals* of the paroxysms, and, if possible, the anatomical condition of the heart which was subjected to this strain.

In these cases the phenomena exhibited by inspection and palpation were that the action of the heart was in many cases irregular in rhythm and also in force, *during* the spasms, and in many cases irregularity was present in the intervals and until the following spasm occurred. The length of time taken for the heart to regain itself varied from about ten seconds to several minutes. The action of the heart was rapid in all cases, in some disproportionately to the respiration.

The data obtained by percussion and auscultation were more accurate. The method of examination by percussion was devised by Dr. Koplik from plates given by Walshe (*Diseases*

of the Heart, p. 3) and by Symington (*Anatomy of the Child*, p. 64). It is as follows (see diagram): A line drawn from the point of apex beat through the junction of the third costosternal articulation on the right side (lower part) represents the median ventricular line. The highest point of the ventricle is the junction of the third rib (lower border) with the sternum



on the right side. The radius of the ventricular base runs from the junction of the fourth rib (lower part) and sternum on left, upward, and strikes the middle or the upper part of the third rib. Dulness noted to the left of mammary line; to right of midsternal line, in fourth space; and on left side on third, fourth, and fifth ribs.

TABLE A.

Case.	Age.	PAROXYSMS.		MEASUREMENTS IN CTM.	
		Intensity.	Frequency.	To right of midsternal line.	With mammary line.
1...	1 yr. & 4 mos.	Severe.	Frequent.	2½	In line.
3...	6 yrs.	Moderate.	Moderate.	1¾	"
8*	3 yrs.	Moderate (heart case).	"	4	"
10...	10 yrs.	Severe.	"	3	"
11	7 yrs.	"	Frequent.	2½	½ outside.
12†	3 yrs.	Mild (heart case).	Few.	2½	½ inside.
13...	1 yr.	Severe.	Frequent.	1¾	¾ inside.
14...	3 yrs.	"	"	2½	In line.
15...	6 yrs.	"	"	2¾	¾ inside.
18...	4 yrs.	"	"	2	"
19...	6 yrs.	"	Moderate.	2½	In line.
21...	10 yrs.	"	Frequent.	3	"
29...	4 yrs.	"	Moderate.	2¼	"
30...	4 yrs.	Moderate.	"	2¼	¾ inside.
33...	4 yrs.	Severe.	Frequent.	2¾	In line.
40...	6 yrs.	"	"	2	¾ inside.

The position of the apex beat in the child is so variously given by different authors that we but state here the position as it was found in these cases—viz.:

In the mammary line, nine cases; inside the mammary line, six cases; outside the mammary line, one case.

Steffen has given the figures for the measurement of the heart to the right of the midsternal line in a great variety of cases. He gives for the ages mentioned 0.11 centimetre less than our measurements show. In some cases of pertussis the heart is found by percussion tests to extend to the right of the midsternal line to an extent equal to the largest measurement normally, and in this series of cases they record the dulness from a centimetre and three-quarters to three centimetres to the right of the midsternal line. Case No. 8, show-

ing four centimetres to the right, is not mentioned here, for the reason given in the table. The percussion in these cases of pertussis can be said to be per-istently large. It is, of course, difficult to fix a dilation which passes the normal only by 0.11 centimetre, but if we find, in a large series of cases, a percussion area which equals the largest limit put down as normal by competent observers, or even surpass this limit, we can justly think of overdistention or relaxation of the ventricle.

In thinking of the causes of possible dilatation of the right ventricle, we note here that Allbut (*St. George's Hospital Reports*, 1870, p. 23) writing of the changes found in the hearts of labourers or soldiers who lifted heavy weights, or who made forced marches while expansion of the chest was hampered by position or clothing, showed in many cases dilatation of the right ventricle, in a less number dilatation of the left, and in a still less number dilatation of both ventricles.

Black (*Lancet*, 1872, vol. ii., p. 253) states that mechanical influences, he considers, are largely responsible for diseases of the right heart, while those of the left heart more frequently arise from tissue inflammation. Again, that the former are passive and secondary, while the latter are active and primary.

We have concluded that, if dilatation of the right ventricle cannot be mapped out, we can conservatively assume from our studies a passive distention of this side of the heart in severe cases of strain in pertussis.

The facts obtained by auscultation were, in part, verifications of former statements. The rhythm of the heart was disturbed in twenty-five out of forty cases. In six cases this disturbance existed to a marked degree, the heart taking a considerable time in which to regain itself after cessation of spasm.

The spasm itself we find thus classically described by Niemeyer (vol. i., p. 95): "The coughing fit begins with a long-drawn, clear piping sound produced as the air is slowly drawn into the contracted glottis. Then follows a series of short, sharp, rapidly-interrupted expiratory coughs, and this in turn is succeeded by the crowing, long-drawn inspiratory act."

The experiments of Müller and Valsalva show that in forced inspiration (Müller) there is the long-drawn inspiratory act, with dilatation of the right heart, congestion of blood-vessels of lungs, with deprivation of blood from the left heart and systemic circulation, and decrease in the pulse tension; and then in forced expiration (Valsalva) the heart is compressed, the veins are congested, the blood is forced into the left ventricle and then out of the thorax, causing emptying of heart and lungs with weakened heart sounds and reduction of the pulse. These experiments reveal the condition of the heart and circulation during or immediately after the paroxysm in pertussis.

In nine of the more severe cases of this series the heart sounds became changed as follows:—

In one case the first sound at apex became roughened.

In one case the first sound at apex was accompanied by a slight murmur.

In one case the second sound became roughened at apex and base.

In six cases the second sound became accentuated—four over the pulmonic orifice, one over the aortic, and one over both orifices.

In two cases loud heart murmurs existed when the children were first seen—one a murmur of aortic insufficiency, the other of mitral insufficiency. These are the cases (Nos. 8 and 12) given in the table as heart cases. It was not determined if the murmurs were old or new.

In regard to the question of heart murmurs in pertussis we quote from Osler: "It is difficult to determine if serious damage ever results. Possibly some of the cases of severe valvular disease in children, who have had neither rheumatism nor scarlet fever, may be attributed to the terrible heart strain during a prolonged attack of whooping cough."

As to the causes of changes in the heart sounds and of the murmurs which arise, we merely question if they may be due to the violent alterations which take place in the heart's own blood supply, or from an impoverished condition of blood generally (hæmic), or to some more purely mechanical causes to which the heart may be subjected, first during the acute dilatation, and then during the acute compression in forced inspiration and forced expiration. The above factors may be active in causing valvular incompetency of a mechanical nature in the intervals of the paroxysms.

That the arterial pulse is disturbed is shown by irregularity, rapidity, dicrotism, and sustained tidal wave. The following

* Case 8, when first seen, was characterised by a loud murmur of aortic insufficiency.

† Murmur of mitral insufficiency present in Case 12 when first seen.

table shows the pulsations persistently rapid and the respirations high:—

TABLE B.

Case.	Pulse.	Respiration.	Case.	Pulse.	Respiration.
2	146	28	26	120	28
"	120	30	"	104	24
"	100	22	"	120	32
"	120	26	"	112	22
15	96	20	35	124	24
"	120	24	37	120	26
"	100	22	"	140	32
16	100	36	"	128	24
26	112	28	"	128	28
"	120	28	"	128	32
"	104	24			

The most marked features of disturbance are dicrotism and sustained tidal wave, these conditions showing, as is well known, abnormal distention and relaxation of the coats of the blood-vessels. These features are plainly shown in the accompanying sphygmographic tracings

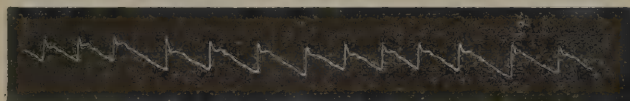


FIG. 1.—Normal trace: healthy child aged thirteen years: irregularity and slight dicrotism.



FIG. 2.—Pertussis, one hour after a paroxysm, showing sustained tidal wave and dicrotism.



FIG. 3.—Pertussis, same as above, five minutes after a paroxysm.

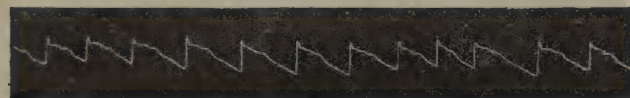


FIG. 4.—Pertussis, showing irregularity and dicrotism; female, aged ten years.

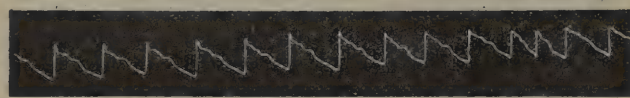


FIG. 5.—Pertussis, same subject as Fig. 4, showing irregularity and dicrotism; female, aged ten years.



FIG. 6.—Dicrotism of pertussis ten minutes after a paroxysm.

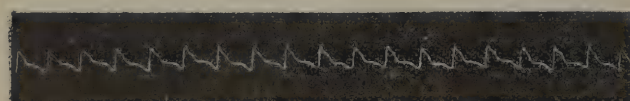


FIG. 7.—Dicrotism of mitral disease, mitral regurgitation.

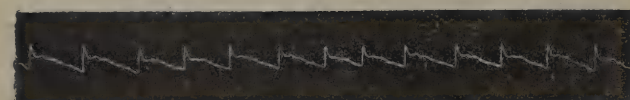


FIG. 8.—Child aged ten years: had pertussis five years ago.



FIG. 9.—Same as Fig. 8.

In two cases where dicrotism existed there was a history of pertussis five years before. We call attention to the fact that slight dicrotism is present in the pulse of the normal child, which is also shown here.

The signs of capillary disturbance are well known—minute hemorrhages, subcutaneous and into the mucous membranes. Signs of venous disturbance are the accepted ones of oedema of face and eyelids, engorgement of the large veins, cyanosis, dyspnoea upon slight exertion, languor, somnolence. Besides these we have the purely subjective symptom of complaint of the heart's action, which occurred in three of the forty cases. In two cases the pain was spoken of as being very severe. The vaso-motor disturbance, as evinced by the flushings, was also marked in some cases. As signs of disturbance of the circulation caused by heart strain, we notice, then, particularly, large heart area to the right, slight changes in the heart sounds, rapid pulse, dicrotism, dyspnoea, languor, somnolence.

Temperature Elevations.—In fifteen per cent. of the cases it was above normal without abnormal lung signs; in one case as high as 101.2° axillary. Some mild cases and some severe ones were ushered in by fever; degree not known.

The percentage of lung complications in the forty cases was as follows: 47.5, slight bronchitis; 20, severe bronchitis; 17, broncho pneumonia; 15, no abnormal lung signs.

Areas of emphysema were present in about twenty per cent. of the cases.

Condition of the Urine.—Steffen found that albumen may be contained in the urine in pertussis. Sugar has been found (Eichhorst, Osler). "Investigations as to blood are wanting" (Steffen). The urine was studied in twenty out of the forty cases—i.e., in those in which it was obtained without catheterisation. Number of examinations made, eighty-six. Reaction acid in all but two examinations. Specific gravity, 1.020, average; from 1.025 to 1.030 during height of paroxysms in several cases, though in some cases even at this period the record shows but 1.004 to 1.006 even where albumen was present.

Table of Urine Examinations.

Case.	Examina- tions.	Albu- men.	Sugar.	Acet- tone.	Blood.	Leuco- cytes.	Casts.
3.....	1	1	1	1	...	...	.....
5.....	2	1	2	...	...	...	.....
2.....	2	...	...	...	...	...	.....
10.....	4	1	2	...	...	...	.....
11.....	12	9	9	1	5	...	(Hyaline, 1 Epithelial, 1.
12.....	3	1	2	...	...	...	.....
15.....	1	...	1	...	...	...	.....
17.....	1	...	1	...	...	...	.....
18.....	7	7	7	...	3	...	.....
19.....	5	3	4	...	...	...	.....
21.....	4	3	4	...	3	...	.....
25.....	1	1	...	...	...	1	.....
26.....	8	8	7	...	4	...	.....
27.....	1	1	...	...	...	...	.....
29.....	7	5	6	..	2	...	.....
30.....	8	6	4	...	2	...	.....
33.....	7	7	6	...	1	1	.....
37.....	8	8	7	...	2	...	.....
38.....	3	3	2	...	2	...	.....
40.....	1	1	1	...	...	...	.....
Total ...	86	66	66	2	24	2	2

The presence of albumen in a large proportion of the cases (sixty-six out of eighty-six examinations), and of hyaline and epithelial casts in a small proportion of the cases (two out of eighty-six examinations), may be due to conditions first suggested by Rosenstein. When, either through insufficient compensation or lack of the same, exhaustion of innervation, fatty degeneration of the heart muscle, or lack of correlation between dilatation and hypertrophy, there results lowered arterial tension and, after a time, surcharge and increased tension of the venous system (as a result of the close relation between pressure conditions and rapidity of circulation on the one hand, and the secretory functions of the kidneys on the other hand), the kidneys, in the lowered arterial tension, excrete less urine than normal, the specific gravity is increased, albumen and fibrin cylinders make their appearance.

Albumen, a few blood-cells, and a few hyaline cylinders were present in one case, which had all the symptoms of heart strain, and in which the albumen and blood persisted for a long time into convalescence. Passive hyperæmia of the kid-

ney in this case could be justly assumed. The albumen and casts, and also the blood-cells, suggest possible effects of an infectious disease, or the blood-cells may have originated from muscular strain. In cases of pertussis, where there are signs of heart strain without fever, the presence of albumen in the urine must weigh in favour of circulatory disturbance in the kidney, as in other parts of the body, in addition to the possible effects of an infectious toxine. The presence of leucocytes is not considered especially worthy of comment. The sugar and acetone may be due to imperfect digestion, and are but mentioned, as their presence has no direct bearing upon the subject of the paper.

Effects of Certain Modes of Treatment.—In all cases antipyrine was administered from the time the children were first seen. In all cases where heart strain was manifest during the intervals (as evidenced by markedly rapid or irregular or dicrotic pulse, by cyanosis, great languor or malaise, by dyspnoea or complaint of heart) digitalis was added to the antipyrine. In all cases where pertussis existed independent of severe broncho-pneumonia the above treatment proved effectual. In three cases, where severe broncho-pneumonia existed and cyanosis was extreme, exhibition of digitalis was followed in twenty-four hours by reduction of unfavourable symptoms. In ten cases, where marked oedema of the face and cyanosis existed without broncho-pneumonia, digitalis markedly relieved the patients. Antipyrine was given in doses of one grain for every year, maximum dose, five grains. Tincture of digitalis, one minim for every year; maximum dose, four minims. The effects of treatment will be best illustrated by citing a few of the cases:

CASE VII.—Celia B—, aged one year; coughing two weeks about fifty times in twenty-four hours; whoops hard; bronchitis present. Antipyrine. The patient failed to report at dispensary; brought ten days later. At this time cyanosis marked, pulse poor, paroxysms severe. Antipyrine and digitalis with great relief in forty-eight hours.

CASE VIII.—Hymen B—, aged three years; coughing three months; expression of intense distress; loud basic murmur of aortic insufficiency, which became much less marked after administration of digitalis, and within one week improvement marked. When seen six weeks afterwards, murmur was scarcely audible. No abnormal lung signs.

CASE X.—Emma W—, aged ten years; coughing three weeks; paroxysms severe, about twelve in twenty-four hours; lies down most of the time; oedema of face and eyelids. Antipyrine. Improvement within five days. No abnormal lung signs.

CASE XI.—Louis L—, aged seven years; coughing three weeks; the last week cough very hard; languor and somnolence, marked oedema, cyanosis, and dyspnoea; albuminuria and casts. Thirteen spasms in twenty-four hours. No abnormal lung signs. Antipyrine and digitalis. In sixteen days, spasms reduced to five in twenty-four hours. When examined two months later, although albumen was present, casts had disappeared from urine.

CASE XXXIII.—Lena W—, aged four years; has been coughing two weeks, whooping two days; eats nothing; languid and somnolent; cyanosis; oedema of face and eyelids; broncho-pneumonia of right side posteriorly; pulse rapid and markedly irregular. Improved upon antipyrine and digitalis, but not until the latter was given in maximum dose for age.

I desire to express my obligations to Dr. Henry Koplik, in whose service in the Good Samaritan Dispensary these studies were made, and who kindly controlled the progress of the work.

THE TREATMENT OF SYPHILIS.

By JAMES D. STAPLE, M.R.C.S.England, L.S.A.London, late Senior House Surgeon, Stockport Infirmary, and Junior House Surgeon, Devon and Cornwall, Norfolk and Norwich, and St. Luke's Hospitals.

[An Original Article specially written for MEDICAL REPRINTS.]

SYPHILIS is a subject full of interest to the practitioner, as so many patients come to him for the treatment of this disease, some of the case being quite easy of diagnosis, having most of the symptoms described in the text-books; but there are other cases, and these are the ones which give us a considerable amount of trouble, in which the diagnosis is by no means easy, and in these we can get little or no assistance from the patient, sometimes indeed we cannot even allow them to know that we suspect syphilis.

I can well remember a surgeon, who had charge of a very large out-patient department in a London hospital, saying that in some very obstinate cases, after the ordinary treatment

had failed, he invariably suspected a syphilitic taint, and treated them as such, and he further added, that this method was generally successful. I myself have verified the truth of this statement on several occasions.

The treatment of syphilis has been well stated in a paper read before one of the medical societies by Dr. S. Wainwright, and reported in the *Lancet*, February 14th, 1891, he gives three methods of treating the earlier symptoms of syphilis:

1. The radical, or Hutchinson's plan.

Small doses of mercury given for a long period, with a view to prevent the appearance of tertiary and even secondary symptoms.

2. The ordinary, or London plan.

Treat the symptoms of syphilis as they arise by internal treatment of mercury.

3. The expectant or Edinburgh plan.

Use only local applications to cure the earlier syphilitic manifestations, and avoid giving mercury internally.

The author prefers the latter plan. I have never seen it used, but from the two other modes of treatment, I have seen very good results.

Dr. Hale White treats syphilis, especially when it affects the nervous system, by the subcutaneous injection of perchloride of mercury, a full account of which is given in a most interesting article in the *Lancet*, June 6th, 1891.

The treatment I have generally given in the secondary stage of this disease has been mercury, and the least irritating preparation of the drug is most certainly that of mercury and chalk. One grain of this should be given in the form of a pill, mixed with a little extract of gentian; if this should cause diarrhoea a little Dover's powder should be given in addition; the patient should also be instructed to be very moderate in the use of alcoholic stimulants, and to take a nutritious diet. The treatment, of course, should never be pushed to the extent of salivation.

In the tertiary stage, iodide of potassium alone is generally recommended, but if the patient has not previously taken mercury, I should give it him, as in this prescription:

Liq. hydrarg. perch. ʒi.

Potass. iodidi gr. v.

Spirit chlorof. m.v.

Decoct. sarsae co. ad ʒi.

two or three times daily, after meals.

In giving iodide of potassium, it is well to remember that the symptoms of iodism may generally be prevented by the addition of spirit ammon. arom.

It is recommended that the treatment of syphilis should be continued for a year after all symptoms have stopped. This is very difficult to carry out, as patients are apt to get impatient and to cease taking their medicine, even if told to continue taking it.

A syphilitic patient who wishes to contract marriage, should certainly not be advised to do so until after all symptoms have ceased for two years, and during this period he should be under treatment.

Recently I have been using "McDade's Succus Alterans" (Lilly), my attention having been drawn to it in the medical papers, and also by seeing this preparation ordered in a prescription by a consulting surgeon. "Martindale and Westcott," in their valuable work, "The Extra Pharmacopœia," state that "McDade's Succus Alterans is a remedy for syphilis, scrofula, jaundice, dropsy depending on liver disease, and for piles; that it consists of the fluid extracts of smilax sarsaparilla, stillingia, lappa minor (burdock), and of phytolacca, of each two ounces, the tincture of xanthoxylum carolinianum (prickly ash) one ounce, the dose being a teaspoonful, increased to a tablespoonful, three times a day before meals.

The *British Medical Journal* has some articles on the use of this vegetable alterative (in 1883 and again in 1887), it has been particularly recommended by such a high authority as the late Dr. Marion Sims, and I believe that he was the first to publish the formula of this preparation.

I selected the following cases for trying McDade's Succus Alterans:—

I. A female, aged thirty-seven, with syphilitic ulceration of both legs and feet; there was a strong history of syphilis, patient having had several miscarriages, children born with "snuffles," and the usual symptoms of syphilis sometime previously.

She was placed under this treatment, and after the drug had been given for a month she gradually improved, and at the end of two months the scabs fell off, and she could get her boots on and walk about. Before this period she had been unable to walk owing to her feet being so painful when standing upon them, and she was now apparently cured.

II. The next case was a man with periostitis of the tibia,

He was forty years of age. There was a suspicion of syphilis, but nothing absolutely definite in the history. This case was more obstinate. The pain was excessive at nights, and sedatives had to be given to procure sleep. Potass iodide in large doses had been given, but without much benefit. The patient had to keep to his house for several weeks. He began to improve about the ninth week of treatment by McDade's Succus Alterans, and six weeks later he resumed his employment. I think one reason for his case being slow was owing to the man taking a large amount of whisky, although told to stop doing so.

III. Syphilitic ulceration of palms of hand in a woman, aged thirty. She had had sore throat, skin eruptions about her body, hair falling off, &c. Succus Alterans (McDade) was given. This case soon improved under the treatment, and in less than two months the ulceration was quite cured.

I should add that in cases I. and III. the only local treatment employed was a little soothing ointment—a mixture of zinc ointment and vaseline.

Whilst admitting that mercury and potass. iodide will probably always remain the treatment for syphilis, still there are undoubtedly cases in which mercury does not agree with the patient, causing salivation, gastric disturbances, &c., and in these cases "McDade's Succus Alterans" will be found most useful.

The advantages which may be distinctly claimed for McDade's Succus Alterans are the following:—

1. It is more palatable.
2. Less apt to cause gastric disturbance, diarrhoea, &c.
3. It has not the depressing effects of iodide of potash, and consequently there is not the same need for giving tonics, codliver-oil, &c., with it.

In conclusion, I would state that I consider "Succus Alterans" most useful, and certainly deserving of a far more extensive use than is at present the case.

OUR ILLUSTRATIONS.

THE JENNER COLLECTION AT THE BRISTOL EXHIBITION.

(Conclusion.)

In our last issue we showed our readers a portrait of Jenner, photographed from the original oil painting in Mr. Mockler's loan collection of Jenner relics at the Bristol Exhibition. We now show another portrait and relics, and an imperfect representation of a case of miniatures of the Rev. W. Hazeland Jenner, nephew; the Rev. George Charles Jenner, nephew; the Rev. Henry Jenner, elder brother; Lieut. Stephen Jenner, nephew; and Anne Jenner, Edward's sister, who married the Rev. W. Davies. The miniatures are all fine examples of that beautiful but now nearly extinct art. A history could be told of each one, and there is a charming story to weave out of the love and sympathy they all bore to the Doctor, feelings which were fully reciprocated. With the miniatures are included two drawings on ivory of vaccine pustules, seventh to eighth, and eighth to ninth days.

On February 25th, 1802, was granted to him the Diploma of Fellow of the Physical Society of Guy's Hospital, and the document is shown under glass in a frame. It is signed by Johannes Houghton, M.D., Thomas Walshman, M.D., Jacobus Curry, M.D., Ricardus Saumarez, Astley Paston Cooper, and Thomas Hardy. What a constellation clustering around a bright particular star! On February 20th, 1802, the same Society presented him with a testimonial and address

signed by the six presidents and one hundred and six members. This also is exhibited at Bristol with other diplomas and certificates—almost every learned and scientific body in Europe presented him with one. Not the least interesting is the Diploma of LL.D. awarded to him by the Senate of Harvardian Cambridge University, Massachusetts, August 31st, 1803. The signatories are: Josephus Willard, S.T.D., LL.D., Proeses; Oliverius Wendell, Simeon Howard, S.T.D., Johannes Lathrop, S.T.D., Eliphalet Pearson, LL.D., Johannes Davis, Socii; Ebenezer Storer, Thesaurarius. Then there are his proxies for the Royal Jennerian Society, 1806; twenty-one cards signed by W. Wilberforce, Beaufort, Devonshire, and others. The Freedoms granted to him by famous cities were also numerous. We have an illustration of one—that of the City of London—presented to him in a gold box of the value of one hundred guineas.

This box, of which we present two representations, is erroneously described in the catalogue as "A magnificent 18-carat gold presentation snuff-box, beautifully enamelled with the arms of the City of London and other subjects, and bearing an interesting inscription; date 1803; 11 oz.

11 dwt." The inscription reads as follows:—"Presented to Edward Jenner, M.D., LL.D., F.R.S., &c., by the Corporation of London, 11th August, 1803, in the Mayoralty of the Right Hon. Charles Price, M.P., as a token of their sense of his skill and perseverance in the discovery of and bringing into general use the vaccine inoculation." There is not the least doubt that this is the casket in which the freedom was presented on August 11th, 1803. Sad to record, the box was sold as a pawnbroker's unredeemed pledge, in October of this year. It fetched £105, exactly the original value, strangely enough.

The other portions of the collection may be briefly summarised. There is the library of printed books, in which will be found first editions of Jenner's few works, together with presentation copies of nearly all the controversial literature which gathered around the Discovery.

We meet with the "Inquiry," &c., again amongst the MSS., where it is to be seen with many notes and alterations in the handwriting of Dr. Edward Jenner, and an autograph

letter dated 1797. There is a large pile of MSS. letters by Jenner to and from his friends and intimates, and some of his correspondence with the great personages of Europe. In some of these are delightful touches of philosophy, love, gentleness, and humour. Sometimes even a few verses, for the great doctor could write elegant lines.

He seems to have set himself to win and retain the esteem, the affection, the love, of all around him, and in this he met with a sure reward. In his minute and account books we get glimpses of the simplicity of life which he had deliberately chosen. There are also the inventories of his effects, the engrossed draft of his will signed by him, and many other interesting documents.

GALLERY OF MEDICAL PORTRAITS.—XXIV.

It is our sad duty to present as this month's instalment of our Portrait Gallery an engraving of the late Sir Andrew Clark—"the beloved physician" of George Eliot's felicitous quotation.

Sir Andrew Clark passed away on Monday afternoon, November 6th. He had never rallied from the paralytic



THE JENNER COLLECTION AT BRISTOL.—CASE OF MINIATURES.

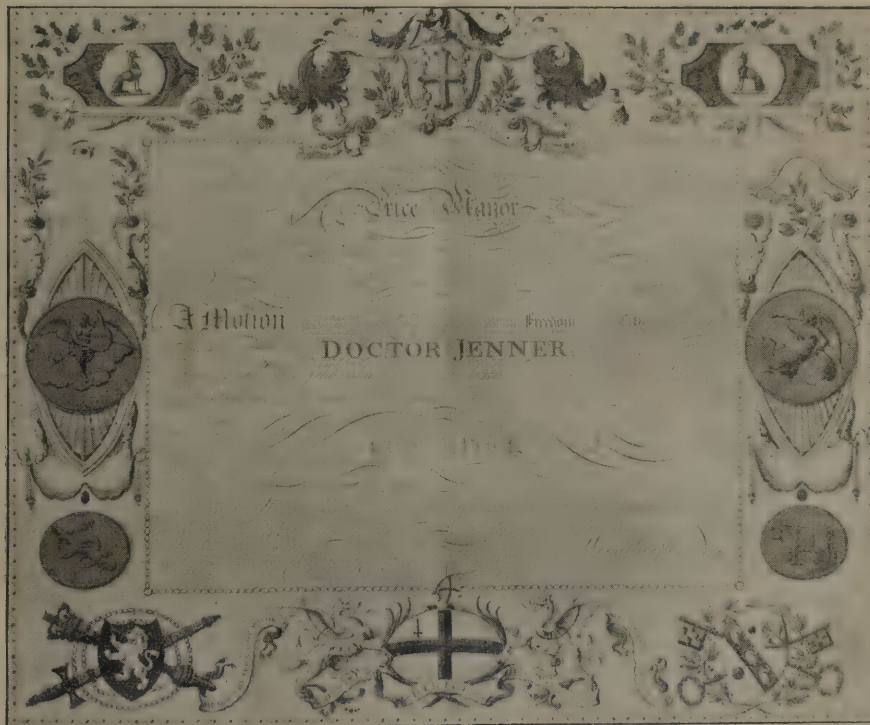
which befell him in his consulting-room on October 19th. He just completed his sixty-seventh year, and the fortieth year of his residence in London. He was a native of Aberdeenshire, and was educated at the Universities of Aberdeen and Edinburgh, obtaining his medical degree at the former University. He entered the medical department of the Royal Navy, and was pathologist to the Royal Naval Hospital, Haslar, for four years. He next gained the appointment of curator to the museum at the London Hospital, followed shortly by his becoming assistant-physician there. To one of the last patients who consulted him, Sir Andrew related for his encouragement what he called "an old man's story" of how he received this post. There had been considerable animosity aroused against the young Scotchman, and the point which assisted in turning the balance in his favour was his delicate health. "Give him the appointment, for he won't live six months," was said by one who was asked for his opinion. Sir Andrew was, as he himself said, much worse at the end of six months, but with native pertinacity he stuck to his post, meanwhile taking the utmost care of himself, and gradually he became sturdier, although he was never a strong man. His connection with the London Hospital continued down to the present time, when he was still lecturer on clinical medicine and senior physician. He had a deep interest in the welfare of the students, and was always ready to give private counsel to them, or to invite them to his home in Cavendish Square. To the work of the Royal College of Physicians, of which he

As one of the most famous physicians of the day, his consulting-room was daily thronged with eminent representatives of every profession. Sir Andrew used to say that the vast proportion of his patients were those suffering from overwork, and for most of these his advice was, "Rest in work, not from work." He was a firm believer in hard work, and was himself an example of it, for he usually was engaged for fourteen hours

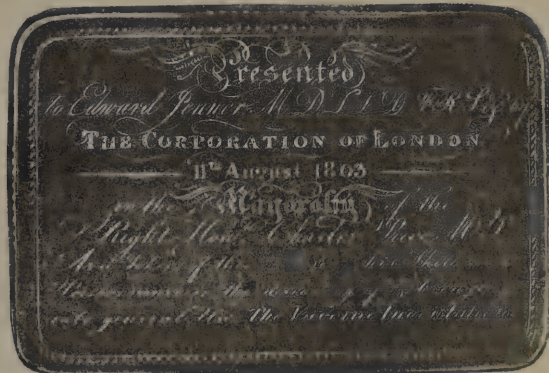
a day, and his enormous correspondence entailed an immense amount of time. Yet, with all these heavy demands, he would constantly write (always in his own characteristic penmanship) kind letters of encouragement and sympathy to those whom he had attended. His busy career was filled with "that best portion of a good man's life—his little, nameless, unremembered acts of kindness and of love." Sir Andrew's close connection with the Premier must needs be mentioned. There was a literary as well as a medical sympathy between Mr. Gladstone and himself, for Sir Andrew Clark was a splendid Greek and Latin scholar. A curious event in his professional work

was a consultation, by means of the cable, on the case of a young nobleman who was lying ill at Newfoundland. He preached to numberless brain workers the Gospel of Hope, and inspired many of his patients with the contagious cheerfulness of his presence. To thousands in all parts of the world the death of Sir Andrew Clark will come as the loss of a sincere friend, as well as of a bright ornament of the profession he adorned.

Any conjecture as to the possible successor of Sir Andrew Clark as physician to Mr. Gladstone would as yet be im-



THE JENNER COLLECTION.—FREEDOM OF THE CITY.



GOLD BOX IN WHICH THE FREEDOM WAS PRESENTED TO JENNER.

was elected a Fellow in 1858, Sir Andrew devoted much energy, and he regarded as the coping-stone of his career the honour of becoming President in 1888—an office to which he was annually re-elected. To chronicle the various distinctions conferred on him would be to give a list of the most prized compliments of the world of medicine. He was created a baronet in 1883, and, besides being a Fellow of the Royal Society, was honorary LL.D. of Cambridge, Edinburgh, and Aberdeen.

properly premature. The known personal friendships of the Premier in the medical profession have necessarily led, in professional circles, to the connection of one or two names with the subject. At the Prime Minister's age, and after the unremitting and affectionate watchfulness with which Mr. Gladstone has for so long been gently ruled in the interests of his own remarkable vitality by Sir Andrew Clark, the post of medical adviser to the veteran statesman will certainly be no sinecure.

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FESSION, INDICATED IN

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ANÆMIA.

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

DECEMBER 15th, 1893.

EXPERIMENTS which have been in progress for some time at
the New York Hospital in reference to the cure of cancer
have now proved so successful that Dr. W. B. Coley, of that
institution, has prepared a report of them which is likely to
prove of permanent value. The fact that the accidental inocu-
lation of a cancer patient with erysipelas has recently been
followed by marked improvement in the cancerous condition,
having suggested the advisability of inoculating other
patients with the erysipelatous virus, a number of cases
were set apart, and experiments were carried out upon them.

For the inoculations a pure culture of the streptococcus
of erysipelas was used, and it was found that about twenty-
five per cent. of the cases of carcinoma were cured, while in
those of sarcoma the percentage of cures was as high as
forty. In order to prove that the benefit thus noted was
not due merely to local reaction, the inoculations were made
in some instances at a distance from the cancerous tumour.
As a rule, however, the injections were made directly into

the tumour, and they were repeated every forty-eight hours.
The reaction produced was similar to that of genuine
erysipelas, though generally much milder in degree, and
passing away in from twenty-four to forty-eight hours.

The following conclusions are drawn from the set of
observations under report. First, that the curative effect
of erysipelas upon malignant tumours is an established
fact. Second, the action upon sarcoma is more power-
ful than upon carcinoma, in about the ratio of three
to one; third, the treatment of inoperable malignant
tumours by repeated inoculations of erysipelas is prac-
ticable and not attended with great risk; fourth, the
curative action is systemic, and probably due chiefly to the
toxic products of the streptococcus; and, fifth, that the
method of inoculation should not be employed indis-
criminately until further clinical experiments have proved
its limitations.

THE warning held out in these columns as to the occa-
sional substitution of inferior mixtures, prepared to that
especial end, for well-known proprietary drugs, has not been
in vain, and now that the profession is acquainted with
the danger, care will no doubt be taken that when
LACTOPEPTINE (RICHARDS) is presented it shall be duly
dispensed. In this connection a remark by a medical man
in large practice is worthy of attention from other readers.
He says, speaking of a mixture imitating closely the
appearance, and to some extent the other characteristics of
LACTOPEPTINE (RICHARDS): "Sometimes, when the price
has been the object, I have allowed the patient to use this,
but always found that its action was next door to *nil*."

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combination of digestive ferments before the profession,
and it has the further great advantage of being exceedingly
palatable. In order that all danger of error can be avoided,
medical men are asked, whenever possible, to direct patients
to obtain LACTOPEPTINE in the original one-ounce bottles in
pink and white wrappers. The wrapping of the bottle
supplied to the public contains no reading matter to which
objection can be raised. It is cheaper to prescribe a drug
that, at a price after all very moderate (since the 4s. 6d.
bottle contains forty-eight ten-grain doses), is *known* to do
its work than to put up with inert imitations.

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almost a specific), and all diseases arising from imperfect
nutrition, such as Anæmia, Cholera Infantum, &c. Weakly
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NEWS AND NOTES.

DR. J. J. CONCANON writes, in the *New York Medical Record*, of a curious case, in which a gold ring was completely overgrown by and embedded in the healthy flesh of the finger, so much so that the patient, a woman of sixty, declined to have it removed. "While treating a child," says Dr. Concanon, "I observed that one of the fingers of her grandmother's right hand was considerably swollen around the first phalanx, a small point of granulation-tissue protruding about an inch from the knuckle. Examination showed a narrow cicatrix extending around the finger, while a hard mass, suggestive of annular productive osteitis, could be felt beneath the skin. The uniform size and shape of the mass, as well as its very slight mobility, soon suggested what it was—an imbedded ring. The woman stated that it was a chased gold ring of the band pattern. She had put it on about nine months ago. When worn for a month, the surrounding tissues became swollen and sore. The ring was not removed, but at the end of another month was completely imbedded and covered over by healthy skin, so that only a slight scar marked its site. Apart from the slight œdema, the finger is in good condition, there being no pain or impairment of joints. The woman refuses to have the ring removed, as it gives her no trouble."

THE question is being debated whether professors at the Medical Faculty of Paris ought to practise their profession. *The Journal des Connaissances Médicales* thinks they should not; the State looks to them to form medical men, to give them the instruction necessary to enable them to maintain the public health in the most satisfactory condition. They should impress upon the pupils who crowd round them a love of study, and instil into them scientific principles. It is the Faculty professors who are to educate medical students to be accomplished, able medical men, fitted to foresee illnesses, to diagnose them, and combat them. In order to fulfil this mission, the professor must be a studious, scientific man. Study is, it is contended, impossible in a life occupied in other ways. A medical practising professor has no time on his hands; frequently a day's work is insufficient to visit all his patients. "Practising medical men," our contemporary concludes, "even the most distinguished and scientific among them, can only keep themselves abreast of the progress directly bearing on medical practice. This knowledge is not sufficient to enable him to form other minds desiring to rank with his own."

NOT many remedies of Queen Mary's (says a writer in *Blackwood*) time retain a place in the modern pharmacopœia. Cardano recommended bark of Indian wood, cinnamon, caryophyllum, colocynth, camphor, cyclamen, viola, turpentine, hops, anise, senna, poppy, mustard, myrrh, wormwood, agrimony, lichen, privet, rue, raisins, hyssop, crocus, marjoram, scabious, figs, honey, and many more; and he earnestly urges the use of a remedy which he had tried himself for breathlessness accompanied by bad cough:—Take the lungs of a fox and forthwith wash them with wine and dry it in a furnace to a cinder; powder, and mix well with the yolk of an egg. It would be interesting to know whether this appetising mixture is to be taken at one dose or divided. Among his external remedies, one which was evidently a prime favourite, was that which he applied over the sutures of the skull, and especially the coronal, and which he found a grand remedy for bringing away the humours of the brain. It was composed of Greek pitch and ship's tar, white mustard,

euphorbium, and honey, sharpened, if necessary, by the addition of blister fly. He had unfounded faith in the efficacy of elæterium—two grains dissolved in four ounces of goat's or cow's milk and as much water, this to be drawn through the nostril when the patient was fasting. He had found that when this remedy was used a very copious discharge of humour took place from the nostrils.

VOMITING during anæsthesia may be arrested by compression of the phrenic nerve and vagus. Dr. Joos, of the Cantonal Hospital, at Winterthur, applies compression with the thumb on the left side, immediately above the sternal end of the clavicle. The hand is held flat on the thorax, and the thumb is parallel with the clavicle. In Dr. Joos's experience the vomiting and hicough forthwith cease. He also suggests that this treatment might be useful for the relief of seasickness.

IDIOSYNCRASY as regards the action of quinine is not uncommon. Dr. Khaikhusara Jivanji reports in *The Indian Medical Record*, the case of a lady suffering from diabetes for whom he prescribed a mixture containing only a grain and a half of the sulphate of quinine, to be taken thrice daily. Immediately

after taking the first dose she felt a troublesome itching on the lower lip, on the lobe of the left ear, and on the dorsum of the left foot, resulting, in about an hour's time, in inflamed patches with troublesome irritation. This irritation passed off in about forty-eight hours, leaving dark spots. The patient stated that whenever she took quinine in any form the result was the same. On one occasion he prescribed for her Easton's syrup in half-drachm doses, with a similar result, but this time the left lobe of the ear and the left cheek alone were affected.

AN American newspaper, the *St. Louis Globe-Democrat*, has soared above the mere blundering to which newspaper writers usually confine themselves when they descant on medical matters. In an account of an operation for traumatic aneurism of the femoral artery, he says that the surgeon "cut a heart out of a man's leg." He goes on as follows: "Instead of being necessary to the patient's existence, as hearts usually are, this organ was a very dangerous possession, and was likely to end his life at any moment. The heart was almost as large as the one usually found inside a man's ribs, and

beat in very much the same manner. It was situated upon the inside of the right leg, four or five inches above the knee, and was more tender than the ball of the owner's eye. . . . The aneurism could be seen to beat to all intents and purposes like any other heart. If one brought his ear close to it he could hear a constantly repeated blowing or breathing sound coming from beneath the skin. This noise was caused by the vacant air space around the swollen artery where it had crowded the muscles aside." The operation is described thus: "A sharp knife laid the tissues aside and exposed the femoral artery with its apple-shaped bulb. The artery was then tied, or 'ligated,' two inches above and two inches below the swelling, and the big bulb cut open. Nearly a pint of blood gushed forth, and then there was no heart left. The slit artery was then sewed together with fine silk threads previously soaked in antiseptic solutions, and left to heal. The ligatures above and below were left to remain, however, until the artery is fully healed. Then they will be untied and the blood allowed to go down Gentry's leg [Gentry, it seems, was the patient's name] as usual. In the meantime the patient's limb will receive blood from the smaller arteries, and will in all probability keep from dying."



THE LATE SIR ANDREW CLARK.

TELEGONY is a term, says *Nature*, which Professor Weissmann has recently coined to designate a class of phenomena which have thus far been pretty generally accepted as of unquestionable occurrence in mammals, if not also in birds, viz., the alleged influence of a previous sire on the progeny of a subsequent one by the same mother. Students of physiology are familiar with the instance of a certain mare covered by a quagga, whose subsequent offspring presented unquestionable quagga characteristics. Within the last twelve months another seemingly unmistakable case of telegony has occurred in the Zoological Gardens, the first foal being a hybrid between two species of ass, and the second by a male of the same species as the mother. Most breeders and fanciers are so persuaded of the truth of "telegony" as to deem a pedigree animal seriously deteriorated in value if she has been covered by an inferior male, and even Darwin thought "there could be no doubt" as to the fact of this influence of a previous sire being occasionally exhibited in mammals. Professor Weissmann, however, challenges the facts, but Professor Romaines has vouchsafed a number of instances plus an explanation in support of the existing view. There is so much margin for mere coincidence in matters such as this that unless the influence can be shown to be tolerably constant one is at liberty to ascribe the occasional traces of the influence of a previous sire to mere accident. Fortunately there is every reason to believe that, even if real, the influence is only exercised when the successive impregnations take place within a comparatively short time of each other. If the alleged phenomenon occurred in *genus homo* there might be unpleasant complications, especially among the female class objected to by the elder Weller.

* * *

THE skull of Sophocles is said to have been found by antiquity hunters in Greece, and it is proposed to lend it to Virchow for examination.

A CORRESPONDENT of *The Pacific Medical Journal* gives the following account of the attractive pharmacy of Bagdad: The practice of medicine is in a degraded state, and patients are constantly bargaining with the physician for a cure, and refuse to pay for advice pure and simple or for an examination, no matter how much skill or time it may involve. When a wealthy person is taken ill all the doctors and magicians in the city are sent for an hour or two apart, and without each other's knowledge, and their advice is followed or not, as it suits the fancy of the women neighbours, who always try to "pump" the doctor by fair means and foul. If a prescription is sent to the drug-store it will probably be put up in an old, unwashed cod-liver-oil bottle that has lain perhaps for months in some dirty corner; an old rag and some paper is made to do service as cork. This is not overdrawn. Sometimes the prescription may be put up in a cup without any cover at all. The percentage-on-prescription system has here been developed and refined as nowhere else. There are benevolent societies whose secretary receives as salary a certain amount on every prescription he has to settle for, and then he and the "doctor" agree that a new prescription shall be written for every dose!

AMERICAN OPINION.

A CASE OF POISONING FROM AN OVERDOSE OF CODEINE.

By WILLIAM PHILIP SPRATLING, M.D.

SHORTLY after ten o'clock on the evening of June 8th, I was requested to see a young married woman, who had taken an overdose of codeine. Immediately after dinner, about seven o'clock in the evening, she had taken sixteen half-grain pills, making eight grains altogether. She had suffered for some months from a painful disease, and had been ordered by her physician to take codeine in quarter-grain doses for the relief of pain, and to overcome a persistent insomnia. Not deeming the quarter-grain pills of sufficient strength, the patient then procured from the druggist a vial labelled as containing one hundred half-grain codeine pills. Three hours before my visit she had swallowed sixteen of these, as she avowed, for the purpose of securing a good night's sleep. An hour later she experienced considerable nausea, and vomited a small quantity of semi-liquid matter. I found her awake, able to converse perfectly well, but extremely restless and irritable. She could not lie in one position, but constantly changed it by tossing,

almost violently, from side to side of the bed. At frequent intervals she would manifest convulsive movements, involving the entire voluntary muscular system. These movements were most marked in the upper extremities and the head. She suffered greatly from intense irritation of the skin over the entire body. This irritation was most annoying along the flexor surfaces of the forearms and on the back. She had an attendant rub her back so vigorously with a coarse towel that the skin in many places was broken. The surface of the body was warm and dry. The pupils were fixed in pinpoint contraction. Respirations were twelve per minute. She complained of great thirst, and an uncomfortable feeling of fullness in the head. I endeavoured to ascertain by repeated questioning whether she experienced any of the pleasant mental effects that follow the exhibition of morphine, but failed to find that such was the case with her at any time during the action of the drug. She frequently remarked that her "thoughts were going round and round." After the painful irritation of the skin had been relieved by sponging the body with solution of bicarbonate of soda, she sank into a light doze, from which she would awake in a few minutes with a start. The skin was hyperæsthetic to a marked degree. She was subjected to the usual treatment for opium-poisoning, and in a few hours was much improved.

By noon on the following day she had fully recovered from the effects of the drug in every way, save that considerable muscular weakness remained. We apparently have no fairly accurate knowledge as to what amount of this drug may be regarded as a fatal dose. In the latest edition of "Wood's Therapeutics" it is stated that "Robiquet in a series of experiments found that doses of 0.01 to 0.03 gm. (0.15 to 0.46 gr.) produced a feeling of contentment, calmed nervousness, and induced refreshing sleep; while 0.1 to 0.2 gm. (1.53 to 3.07 gr.) caused deep sleep followed by nausea and vomiting." Quoting further from the same author, he adds, "Dr. A. S. Myrtille¹ records a case of serious poisoning by four grains of codeine." And Dr. D. Walsh² reports serious poisoning by eight grains of codeine.

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

TUBERCULOUS PERITONITIS is considered by Mader to disappear after laparotomy, because of the entrance of air, the evacuation of the fluid, and the crowding together of the layers of the peritoneum due to the dressing.

INTESTINAL FLATULENCE.—

Powdered coriander	}	each, 5 parts.
Powdered peppermint		
Powdered vanilla		
Powdered senna	... ..	1 part.

A teaspoonful two or three times a day.

—MONIN.

SULPHUR IN CHLOROSIS.—Professor A. Schulz (*Deutsche Medicinische Wochenschrift*, No. 36, 1893) calls attention to the immense importance of sulphur in the human economy, and recommends it in the treatment of chlorosis. In cases of pure chlorosis, where iron is inactive, the general condition is greatly improved by the administration of sulphur, and after sulphur has been taken for some time administration of iron could then be commenced. In cases of chlorosis with catarrhal inflammatory states of the digestive tract it is not well tolerated.

LICHEN PLANUS, with intense pruritis and nerve disturbances, has been relieved by Jacquet with the hot douche.

TREATMENT OF ACUTE AND CHRONIC RHEUMATISM.—For the last six years M. Ruel has treated externally only acute or chronic rheumatism. Compresses steeped in the following solution are applied twice a day to the articulation, and covered with oil-silk so as to prevent evaporation:—

R	Salicylic acid	... ..	3 v.
	Proof spirit	... ..	3 iij.
	Castor-oil	... ..	3 vij.
	Chloroform	... ..	3 iv.

When the applications are properly made, the salicylic acid appears in the urine twenty-four hours after.—*Medical Press.*

¹ *British Medical Journal*, 1874, i.

² *Ibid*, 1888, ii.

GASTRIC AND OTHER NERVOUS SYMPTOMS OF NEURASTHENICS.—Drs. Rummo and Braccini (*Semaine Medicale*, No. 54 1893), recommend the following pill, in the gastric and other nervous symptoms of neurasthenics:—

R Phosphide of zinc ... grs. jss.
Bromide of zinc ... grs. xv.
Bromohydrate of quinine ... grs. xxijss.
Extract of nux vomica ... grs. ij.
M. Thirty pills.
Three pills per diem.

LATE OCULAR MANIFESTATIONS of syphilis are treated by sub-conjunctival injection of one drop of a one to one thousand solution of corrosive sublimate.—**ABADIE.**

CALOMEL IN GOUT.—About fourteen years ago Dr. F. Grimm (*Deutsche Medicinische Wochenschrift*, Nos. 15, 18, 1893), administered calomel to a patient who was suffering from a protracted attack of gout. The next day he remarked a material improvement and a retrogression of the symptoms. In the meantime he has tried the remedy in about twenty cases of gout. In some cases the result was astonishing, for it acted like a specific, while in others the immediate relief was followed by a slower recovery. He ascribes its action to the active peristalsis which results, for in robust subjects an attack of gout is usually preceded by sluggishness of the bowels. In such cases is the result the most favourable. The remedy must be so given that active peristalsis will result from the very first dose. One catharsis is generally sufficient to inaugurate the improvement and to continue it. Long treatment is not indicated. After the calomel a carminative may be prescribed. Besides calomel he has also used the yellow iodide of mercury, which appears to act more energetically. His observations are confined to acute and subacute articular gout and its immediate sequelæ. Relapses are not more frequent than after other methods of treatment.

BLENNORRAGIC CYSTITIS.—From all points of view nitrate of silver possesses an incontestible superiority over other therapeutic agents.—**DESNOS.**

PSORIASIS.—The application of chrysarobin in chloroform (1 to 10) was found to be the most successful treatment.—**HAUMER.**

FAVUS.—

Naphtol beta ... gr. xij.
Balsam of Peru ... j.
Vaseline... .. centum.

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THE Proprietor of this publication is desirous of obtaining for publication in MEDICAL REPRINTS original essays and clinical notes on subjects full particulars of which will be obtained on application by letter to

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CAULOCOREA—SAMPLES.

THE great number of requests lately received for samples of the above article having entirely exhausted the supply of samples in the hands of the agent, he regrets that he is thus unavoidably obliged to disappoint many correspondents, to whom his apologies are respectfully conveyed.

BACK NUMBERS OF MEDICAL REPRINTS.

The following issues are out of print:—

No. 1 (February, 1890). No. 14 (March, 1891).
No. 7 (July, 1890). No. 17 (June, 1891).
No. 10 (November, 1890). No. 19 (August, 1891).
No. 13 (February, 1891). No. 22 (November, 1891).

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[For contents of numbers dated earlier than March, 1893, see former issues of MEDICAL REPRINTS.]

No. 38 (March, 1893) contains:—

Constipation. By J. D. Staple, M.R.C.S. Eng. (Original Article.)
How Amputation of the Breast for Carcinoma should be Performed. By Prof. R. F. Weir, M.D. (With Two Illustrations.)
Spontaneous Cure of Multiple Papillomata of the Larynx after Tracheotomy; with the rare Anomaly of Papilloma of the Epiglottis. (With Four Illustrations.)—Medical Literature.—II. A Book of the Month. Reviewed by E. A. Piggott, L.R.C.P. and S. Edin., &c.—Books.—News and Notes.—American Opinion: Digitalis in Pneumonia; Barium Chloride in Epilepsy; How to Cure Eczema.—A New Disinfectant Soap.—Therapeutic Notes.—Views: The Bristol Medical School: Exterior, Entrance Hall, and Lecture Theatre.

No. 39 (April, 1893) contains:—

Cylindroids, or so-called Mucous Casts. By M. Manges, A.M., M.D. (With Six Illustrations.)
A Gynaecological Study. (Original Article.) By E. A. Piggott, L.R.C.P. and S. Edin., &c.—Some Physiological Experiments with Magnets. By F. Peterson, M.D., and A. E. Kennelly, Electrician. (With Four Illustrations.)
Relationship of Rheumatic Fever, Heart Disease, and Chorea. (Original Article.) By W. Downing, L.R.C.P. London, M.R.C.S. Eng.—Books.—American Opinion.—News and Notes.—Medical Literature.—III. A Book of the Month. Reviewed by J. D. Staple, M.R.C.S., &c.—Therapeutic Notes.—Correspondence.—Illustrations: The Konigl. Charité, Berlin. Four views.

No. 40 (May, 1893) contains:—

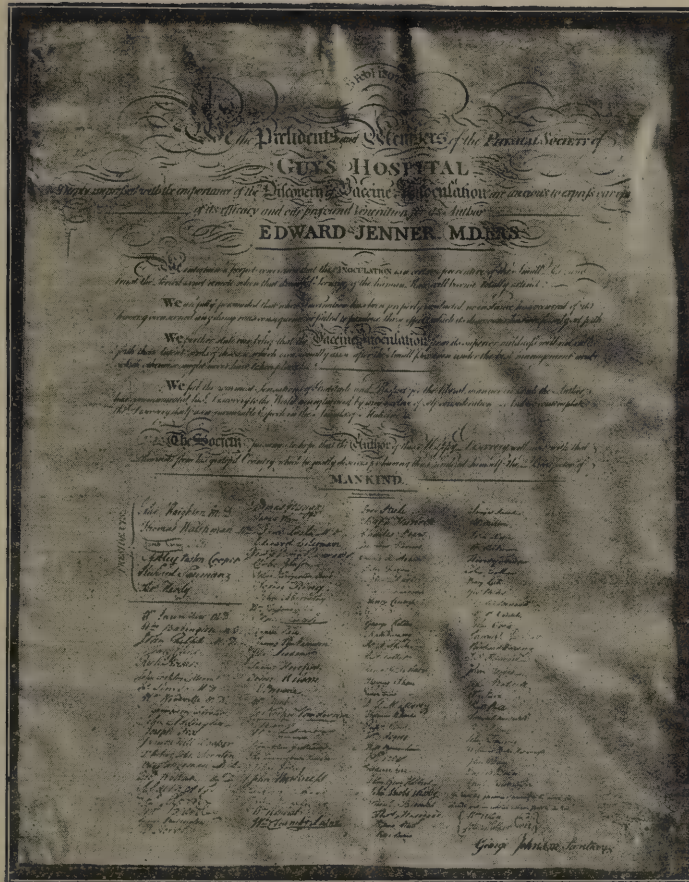
Dyspepsia Among the Textile Trade Operatives, its Causation and Treatment. By J. A. Diggle, L.S.A. Lond. (Original Article.)
On the Importance of Examination and Flushing of the Genital Tract Directly after Labour. By Alexander Duke, F.R.C.P.I., &c. (Original Essay.)
The Result of Examinations of Sewer Gas which Escaped in Tenement and Private Houses, wherein Cases of Diphtheria Occurred. (With Three Illustrations.)
Cylindroids or So-called Mucous Casts, concluded. (With Three Illustrations.)—News and Notes.—Medical Literature.—IV. A Book of the Month.—Books.—Glycerine in Constipation.—American Opinion:—Internal Urethrotomy.—Therapeutic Notes.—Correspondence.

No. 41 (June, 1893) contains:—

Urethral Fever. By P. Macleod Yearsley, M.R.C.S. Eng. (Original Article.)
Three Cases of Syphilis. By J. A. Diggle, L.S.A. (Original Article.)
Osteitis Deformans. By H. Ling Taylor, M.D. (With Five Illustrations.)
Vaginodynia. By E. F. Frost, M.D. Case of General Dyscrasia. By F. P. Emerson, M.D.—Books.—News and Notes.—Continental Practice.—American Opinion.—Therapeutic Notes.—Portrait: The late Prof. Marcus Beck.

No. 42 (July, 1893) contains:—

Proper Duration of the Lying-in Period. By H. Seymour Houghton, M.D., &c. Tatooing and its Removal. By Professor A. H. Ohmann,



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The Surgery of Gall-Stone Obstruction. By Professor Robert Abbe, M.D., &c. (With Six Illustrations.) Damiana, a Nerve Tonic and Stimulant, with Cases. By J. A. Diggle, L.S.A., &c. (Original Article.) Extensive Wound of Arm and Axilla—Healing Without Cicatricial Contraction. By A. Radcliffe, M.D. (With two Illustrations.) Frequency of Throat Diseases in New York School Children. By Maria M. Vinton, M.A., M.D., &c. Procidencia Uteri in a Pregnant Woman. By A. Jeffery, M.D.—News and Notes.—American Opinion.—Therapeutic Notes.—Correspondence, &c.—Portrait: The late Dr. John Rae.

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English Cholera: Its Cause and Treatment. By William Duncan, L.F.P.S. Glas. (Original Article.) Notes on Seven Cases of Dyspepsia. By J. A. Diggle, L.S.A. London. (Original Article.) Strangulated Femoral Hernia: Resection of the Gut at the End of Eleven Days: End-to-End Anastomosis: Recovery. By Ap-Morgan Vance, M.D., &c. (With Six Illustrations.) A Case of Cardiac Disease, complicated with Gastric and Hepatic Symptoms. By Geo. Selkirk Jones, Ph.D., L.S.A. (Original Article.) Ingrown Toe-Nail: Its Surgical Treatment. By W. R. Howard, M.D. (With Six Illustrations.) Case of Nasal Polypus. By S. Johnston, M.D. (With Three Illustrations.) A Word of Caution. (With Three Illustrations.)—News and Notes.—American Opinion.—The Children's Hospital. (With Eight Illustrations.)—Therapeutic Notes.—Correspondence. Portraits: The late Professor Charcot; Sir Charles Cameron, Bart., M.P.

No. 45 (October, 1893, Hunter Centenary Number) contains:—

Dr. Koch on the Diagnosis of Cholera. Diarrhoea in Children and its Treatment. By W. Duncan, L.F.P.S. Glasgow, &c. (Original Article.) Appendicitis. By R. T. Morris, M.A., M.D. (With Two Illustrations.) A New Sacral Operation. By G. E. Abbott, M.D., &c. (With an Illustration.) On Substituted Digestion. By Geo. Selkirk Jones, Ph.D., L.S.A. (Original Article.) Oxygen in Cholera. By R. Harcourt, M.D., &c. The Hunter Centenary. (With Ten Illustrations.) The late Dr. Parke and the late Dr. Chas. Clay.—News and Notes.—American Opinion.—Correspondence.—Therapeutic Notes.—Portraits: Dr. Parke; Dr. Chas. Clay.

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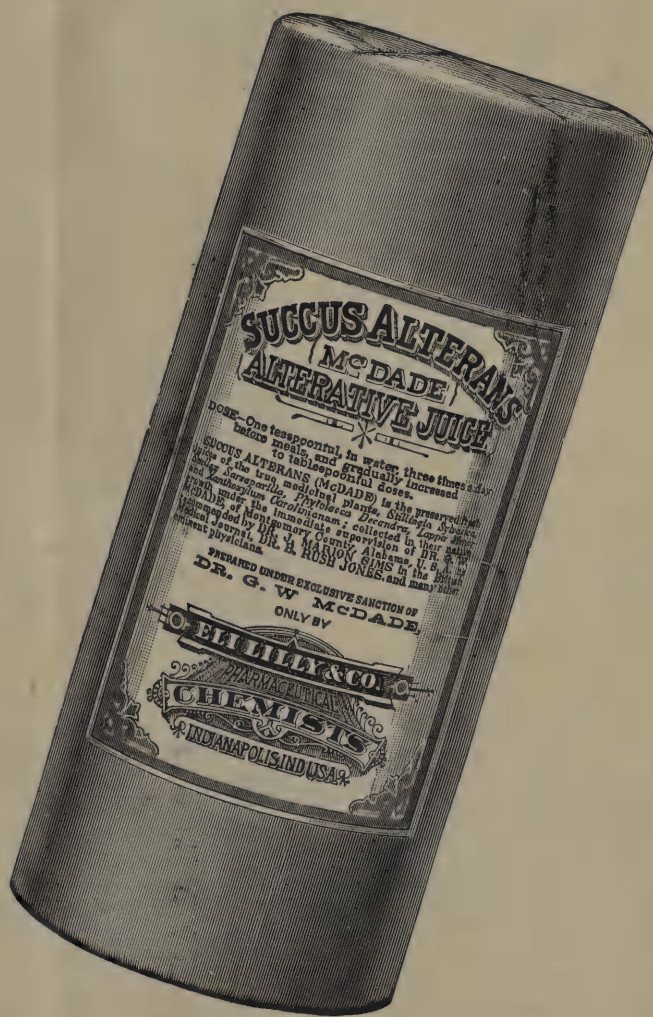
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RECTAL STRICTURE OF PUERPERAL ORIGIN RELIEVED BY LAPAROTOMY.

By N. STONE SCOTT, M.D., Cleveland, U.S., Consulting Surgeon to the City Hospital; Visiting Physician to Charity Hospital; Lecturer on Osteology and Genito-Urinary Diseases, University of Wooster.

[Read at the Meeting of the Ohio State Medical Society.]

It is with considerable trepidation that I offer a new classification of rectal stricture. The case I have to report to-day has been of especial interest to me, and, on looking up the literature, appears to be unique. The consideration of the subject forces me to divide rectal stricture into true and false.

In true stricture the pathological narrowing is situated in one or more of the structures of the rectum.

By false stricture of the rectum will be understood a stricture wherein the pathological condition is situated in the perirectal tissues, and not in the structures of the rectum. This must not be confounded with obstruction of the rectum caused by a tumour or misplaced organ.

With true stricture and with obstruction of the rectum this paper does not deal; but it is my wish to show that false stricture not only exists, but may be better treated than by the methods recommended in the text-books. The case giving rise to this research is as follows:—

SYNOPSIS.—Symptoms of rectal stricture following confinement. Laparotomy. Recovery, with a complete cure of the stricture.

HISTORY.—Mrs. M—, aged thirty-six, a large, well-built woman, has always enjoyed good health until her last confinement. She first menstruated at seventeen years; her periods have been regular in time and quantity, and accomplished without difficulty. She has given birth to four children; one ten years since, one six, the third three years ago, and one in April, 1892. All the labours were easy, and convalescence normal except the last. The first child died at the age of seventeen months, of diphtheria; the last one lived but twelve days; the other two are healthy. No trace of syphilis or gonorrhœa in husband or wife. On the second day after confinement she complained of severe pain in the lower part of the abdomen, and on the eighth day a rectal tenesmus supervened, there being frequent passages of mucus streaked with blood. This continued some two months; gradually the acute pain and bloody discharge subsided, but she did not regain her former good health.

Her doctor told her that she had “influenza of the bowels.” No vaginal examination was made. In July she consulted one of our leading gynecologists, who put her to bed, gave her hot douches, and said to her, “You will have to stay in bed until the snow flies.” For two and a half months she had no symptoms directly referable to the rectum, but after the latter part of August the difficulty she experienced in getting her bowels to move gradually increased in severity.

On October 25th my father first saw the patient. At this time she was having a chill every day or every other day, with a temperature from 100° to 101° F. The next week I saw her. She was then in a deplorable condition; her entire trouble was referred by herself to the difficulty in getting a passage, which she dreaded on account of the pain, which she described as “something terrible, forcing her to bear down as if she were ‘going to have a baby.’” A movement was only secured by the repeated administration of large doses of powerful cathartics, and was accompanied by a distressing, burning sensation in the rectum, which could not be relieved. The anus, she said, would at these times “draw up toward the inside,” while the passage was “very small, like a baby’s.” Her other symptoms were accompanied by a persistent anorexia and daily vomiting, that threatened a speedy termination unless relief should be obtained.

A rectal examination revealed, at three and a half inches, a firm annular stricture, so small and resisting that the examining finger could not be made to engage in it. On making a vaginal examination, the cervix was free—that is, as free as

is possible with a fixed fundus. The fundus was retroflected, drawn to the left, and firmly fixed to the sacrum. Passing from the fundus laterally could be felt on either side a firm band, not sensitive to pressure, shorter and thicker on the left than on the right side. These bands occupied the site of the superior border of the broad ligament, passing off from either side of the uterus at its fundus, but did not extend throughout the width of the broad ligaments down to the cervix. Ovaries and tubes not to be differentiated.

On November 15th, assisted by the house staff at Charity Hospital, in the presence of Drs. W. J. Scott, Weber, and Lucas, I opened the abdomen by a four-inch incision, with the expectation of at least partially relieving the rectum by freeing the uterus, lifting it up, and doing a ventro-fixation. The uterus was retroflected, drawn to the left, and fixed to the sacrum. So firm were the adhesions, and to such an extent had the cicatricial contraction taken place, that the peritoneum of the fundus had a white, glistening, bloodless, appearance. The left tube and ovary were not found, but their site was occupied by a mass of new connective tissue. The rectum skirted along the promontory of the sacrum just above the fundus of the uterus, and dipped down into the pelvis to the right of that organ, instead of the left, where it is usually found. Commencing above to free the rectum, the vermiform appendix was found adherent to its anterior surface; this was freed, and being normal, was put over into its proper place. The tube and ovary, containing a small cyst which ruptured during the manipulations, were next lifted from the rectum. Very little ovarian tissue was left, the most of it being substituted by cicatricial tissue. The right broad and the round ligaments were found to be much shortened, these, reinforced by the inflammatory new connective tissue between the rectum and broad ligament, formed a firm stricture of the rectum. The broad ligament, including the round ligament, was cut between forceps well down into “Douglas’s pouch,” and the anterior and posterior layer of peritoneum stitched together on either side of the cut. After stopping the oozing, and flushing the abdomen, the external incision was closed with silkworm gut. A rectal examination showed that the stricture had been immediately relieved.

I have prepared some diagrams to illustrate the condition at the time of operation.

Fig. 1, after Savage, I have modified to represent a transverse section of the body, showing the normal position of the fundus uteri, situated at about the centre of the pelvic cavity, with the broad ligament and the structures contained therein, the ovary, tube, and round ligament passing out literally to the pelvic walls.

Fig. 2 represents a transverse section of the body, showing the site of the inflammatory exudate and adhesions. This chart is largely hypothetical; as there was no vaginal examination for several months after the confinement, there is no way of knowing how much of an exudate there was during the earlier stages.

Fig. 3 represents a transverse section of the body, showing the relation of the pelvic viscera, in the case under discussion, at the time of the operation. The rectum passes down into the pelvis on the right side, the uterus is drawn to the left, and fixed. To the left of the uterus is the short band of connective tissue enclosing the remains of the ovary, tube, and broad ligament. To the right of the uterus the broad ligament, passing from the fixed uterus on the one hand to the pelvic wall on the other, shortened and reinforced by the inflammatory new connective tissue, forms a firm band, pressing down upon the rectum, and preventing that organ from performing its natural functions. *N* represents the site of the operation.

Convalescence was uneventful. One month after the operation I have in my notes the following: “Feels perfectly well. Cannot get enough to eat, but suffers no discomfort from eating. As soon as her head touches the pillow she is asleep; first restful sleep since last April. Bowels move every day, and has taken cathartic but once since coming home.” To-day, six months after the operation, she says her health is

better than ever before. Surely not the ordinary result of an operation for stricture of the rectum by the old methods!

The literature of the subject contains numerous cases of obstruction of the intestinal tract by bands of various kinds; some of them extending to the true pelvis, or even located in it; but the following three cases only may be fairly called false stricture of the rectum, although not so reported.



FIG. 1.—Transverse Section of the Body, Showing Normal Position of Fundus Uteri; A, hypogastric artery; A', spermatic vessel and nerve; B, broad ligament; C, sacro-uterine ligament; G, ureter; O, ovary; T, tube; RL, round ligament; V, last lumbar vertebra; dotted line indicates the true pelvis. (Modified from Savage.)

In 1854-55,¹ Mr. T. J. Ashton exhibited to the London Pathological Society a specimen showing "Stricture of the rectum, from a deposit of fibrous tissue external to its coats."

"F—, aged fifty-four, admitted to hospital with a history of disease of the rectum of twenty years' standing; examination showed a contraction of the bowel to exist at three inches from the anus, surrounded by a dense mass of morbid structure. On post-mortem examination, the intestines were found greatly distended. No peritoneal inflammation existed. The rectum contracted at the part already mentioned, and was surrounded by a large mass, having the appearance of fat, and very dense; but by the aid of the microscope, as well as subjecting the specimen to the action of ether, it was found to be composed of fibrous tissue alone."

January 11, 1893,² Dr. Biggs exhibited to the New York Pathological Society a specimen of which he says: "It was removed from a woman, thirty-five years of age. There were extensive adhesions from the upper border of the uterus directly backward to the rectum. It was interesting to note that the origin of the trouble was tubal. A firm band of

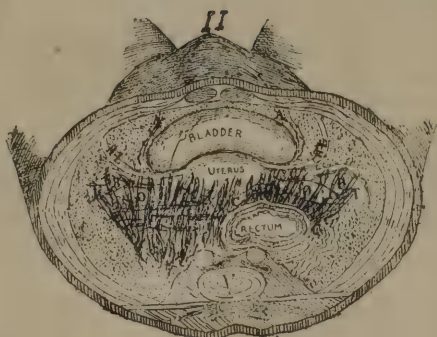


FIG. 2 (hypothetical).—Transverse Section of the Body, Showing the Site of the Inflammatory Exudate. (References as in Fig. 1.)

fibrous tissue, nearly half an inch thick, surrounded the middle portion of the rectum, causing so much obstruction that it was with difficulty that the little finger could be forced through the opening. Above this point there was very marked dilatation of the gut, and in the sigmoid flexure and ascending colon there was very extensive diphtheritic inflammation."

Dr. Edwards³ also reports a case found at post-mortem, in

which "The cause of all the trouble was a cartilaginous band, about one and a half or two inches wide, which had gradually occluded the gut completely from seven and a half to nine inches above the anus."

It is probable that most false strictures are due to an inflammatory process starting without the rectum. Dr. Biggs's case was apparently of that character, and my own was undoubtedly the result of such an inflammation.

That the latter was of puerperal origin there can be no doubt, as the history is clear on this point. None of the older authors mention the puerperal condition as an etiological factor of stricture of the rectum. Whitehead, even as late as 1888, in a lengthy address on stricture of the rectum, says: "I have no knowledge whatever of child-bearing as a cause of rectal stricture." The modern authors are, however, beginning to recognise it as an etiological factor. Wyeth's and Moullin's Surgeries contain the simple assertion that the "accidents of parturition not infrequently tend to stricture."

The differential diagnosis between true and false stricture is most difficult, since there is no pathognomonic sign or symptom. The clinical history of both are alike; a rectal examination reveals apparently the same condition. But if on vaginal examination, or otherwise, a pelvic band can be felt, especially if the uterus is fixed posteriorly, the stricture may be suspected as a false stricture. May it not be that quite a proportion of those found in women are false strictures?

Let us review for a moment the methods of treatment advocated for stricture of the rectum. They are, combined with constitutional treatment, the bougie, linear proctotomy, and colotomy.

The use of the bougie is not without danger, and even after



FIG. 3.—Transverse Section of the Body, Showing the Relations of the Pelvic viscera in the Case of Rectal Stricture of Mrs. M.: RL, round ligament; C, cicatricial mass including the left tube and ovary; O, right ovary, adherent to rectum, covered by new connective tissue; N, site of operation.

the stricture has been fully dilated, the instrument must be passed at intervals to prevent its recontraction. Surely not a cure!

Of linear proctotomy, "The American Text-book of Surgery" says: "It cannot be practised when the stricture is high up or of great extent; here we must perform colotomy to save the patient's life." The four cases forming the basis of this paper were from three to seven and a half inches from the anus; and it is not improbable that most false strictures are high up, situated above the floor of Douglas' pouch. Any operation through the rectum must not only cut through sound tissues, exposing them to the dangers of infection, but, if the operation is thorough enough to divide the constricting band, must also open the peritoneal cavity, which is the danger to be feared in linear proctotomy.

Colotomy is rightly a last resort; and if a case judged to be a false stricture proves, on opening the abdomen, not to be directly amenable to surgical treatment, a colotomy can be performed, and the median abdominal incision closed, without materially adding to the dangers of the colotomy.

I have endeavoured to show that there are cases of stricture where the pathological condition is situated outside of the rectum. These I have denominated false stricture, in contradistinction to true stricture.

False stricture is usually the result of an inflammation starting without the rectum.

The puerperal condition is an important etiological factor.

Presents the same clinical picture as the true stricture.

Situated above the floor of Douglas' pouch.

Theoretically, false stricture can be best treated by laparotomy.

¹ Transactions of the Pathological Society of London, 1854-55.

² New York Medical Record, February 4, 1893

³ Ibid., April 21, 1888.

CHRONIC DYSPEPSIAS: A DIFFICULTY SOLVED.

By A. E. HUBAND, L.R.C.P. Edin., L.R.C.S. Edin., L.F.P.S. Glas.

[An Original Article specially written for MEDICAL REPRINTS.]

AMONG the variety of complaints which the general practitioner is called upon to treat, I think no one is more common or universal than dyspepsia in its various forms, and although generally not looked upon in so serious a light as functional derangements or structural alterations of the heart, lungs, kidneys, nevertheless, is often a source of trouble to the doctor, and is still a far greater annoyance to the patient. How often do we find chronic dyspeptics going first to one then another practitioner, interspersing their treatment with resorts to domestic remedies, quack remedies, and so on. Now, if the prescriber can alleviate the symptoms, or effect a cure, he is looked upon with immense satisfaction by the patient, in addition to acquiring his gratitude and good words—and in a great measure our success depends upon the criticism of our patients. The armamentarium for combatting dyspepsia contains an almost *ad infinitum* list of remedies in the shape of vegetable, mineral, and animal preparations, so much so that we are often tempted to try the effect of something new, or at any rate, something out of the beaten track. So far as regards vegetable and mineral preparations, their uses and abuses are so well known in the majority of cases as not to call for any special comment.

In thinking over some of the causes of dyspepsia, such, for instance, as the cases of people with defective or absent teeth, resulting in imperfect mastication and consequent imposition of extra work upon a willing stomach; the chronic drunkard, who through his alcoholic excesses has damaged his peptic glands, and so on. The preparations of pepsin in so many of these cases are so useful; but there is one thing militates against their use, they are bad keepers. And to administer animal derivatives not so palatable or so active as they should be to our patients, certainly does not cause us to rise in their estimation. After trying a variety of these pepsin preparations, the one that I have found to answer the requirements of being palatable, free from decomposing odour, and one that will keep, that is easy of administration, is Lactopeptine, a powder containing, in addition to pepsin, pancreatine, ptyalin, lactic acid, hydrochloric acid, and sugar of milk. Whenever I find it necessary to administer pepsin or pancreatine, I find this combination *the one par excellence*. Looking at it from another point of view, I have come to the conclusion that it is quite as easy to prescribe an elegant and well made preparation as well as a crude and indifferently prepared one; and in chronic dyspeptics we may rest assured that in the majority of cases they have swallowed a considerable quantity of nauseating substances, and that a change to something that can be taken with pleasure and without a feeling of repulsion comes as a boon and a blessing to them.

One of the greatest successes I ever had in treating dyspepsia was the case of a maiden lady who had suffered for years from chronic constipation, and had a dilated stomach, probably owing to the constipation and the amount of medicine she had taken. From her history I gathered she must have pretty well exhausted the list of aperient and digestive remedies. Finding she had not tried Lactopeptine, I prescribed five grains with each meal, and in place of the ordinary purgative ordered the use of J. M. Richards' "Glycones (Lilly)." The result was immensely satisfactory in alleviating her symptoms, although the stomacheal condition was not cured. She was enabled to enjoy life, comparatively speaking, without punishing herself by dosing with unpalatable medicines.

AN ENORMOUS CEREBRAL TUMOUR.

By WILLIAM E. CONROY, A.M., M.D.

THE phenomenal size of the encephalic tumour here described renders the case, I think, worthy of record, although I am unable to report it as accurately as I could wish, having, unfortunately, lost my notes. The main features of the case, however, are these:—

F. H., aged twenty years, American by birth and parentage, came to my office accompanied by his mother, who requested me to examine his eyes, saying that his vision had been failing for about two years. I obtained the following history: F. was an unusually bright boy until his fourteenth year, when he was knocked down and kicked in the head by a horse. The blow rendered him for a short time unconscious, but he apparently recovered completely. Soon after, however, it was noticed that he was gradually losing his hearing. The deaf-

ness increased slowly, and, about a year after the accident, paralysis of the right arm and leg developed. Next his speech became affected, and finally his eyesight began to fail. The mother also thought that for the last few years the boy's head had been increasing in size.

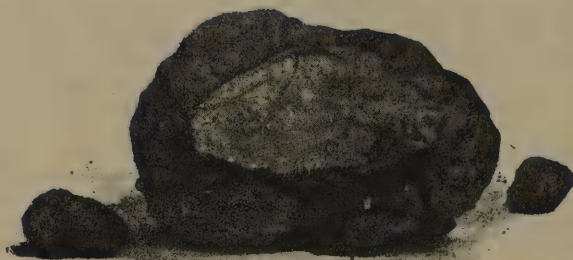
Status Præsens.—Height, five feet five inches and a half. Body well nourished, muscles well developed, and plenty of adipose. Measurements of arms and legs of right and left sides show no marked difference. Facial expression rather dull. Tongue protrudes to the left. Sensation blunted over entire right side, right arm and leg, most marked in leg. Paralysis of motion nearly complete in right lower extremity; right arm and hand much weaker than left. Electrical reactions not taken. Head square, of hydrocephalic type; circumference at level of frontal eminence thirty-three inches. *Ears*.—Tympanic membranes normal in appearance; no ankylosis of incostapedial joints. Eustachian tubes patulous. Hears only the loudest sounds, there being apparently no difference in hearing capacity between right and left ears. *Eyes*.—External structures normal. Pupils dilated, the left rather larger than the right, and do not react either to light or to efforts at accommodation. A very marked neuroretinitis in both eyes, that of the left advancing to the atrophic stage. No heterophoria. Vision in the right eye is reduced to recognition of No. L Snellen at a few inches from the eye. With the left eye he can only count fingers at about a foot distant.

Articulation very indistinct. There is a depression in the skull at about the location of the left parietal foramen, but no cicatrix. Pressure over this spot causes pain. The mother states that the boy's appetite is enormous, and that he sleeps well. I think she told me that he had suffered from several convulsive seizures, during which he lost consciousness, but that he did not foam at the mouth or bite his tongue. There are no scars on the tongue. I made a diagnosis of cerebral tumour, probably in the occipito parietal region. This was in August, 1889. I did not see the boy again until the following January, when I was asked to consult with the late Dr. B. B. Ross, as to the propriety of an operation. The only change that had occurred was that both optic nerves were now markedly atrophied and vision was reduced to a perception of a hand placed between the eyes and a bright light. Dr. Ross agreed with the diagnosis of tumour, and, after explaining to the mother the certainty of a fatal issue if the case was left to Nature, and the danger of operation, with the extremely slight chance of benefit therefrom, she requested us to operate. Accordingly, on the 2nd of February, 1889, Dr. Ross trephined, assisted by Dr. Barber, Dr. Sawyer, Dr. Schemm, the writer, and others. The operation was performed under strict antiseptic precautions, a curved incision being made with its centre close to the depression in the skull before mentioned. This depression proved to be an opening in the bone, apparently caused by absorption, the surrounding bone being very thin. About two square inches were removed with trephine and bone forceps, when the dura bulged through the opening very dark, almost black in colour. Incision of the dura revealed a hard, lobulated mass, looking very like brain tissue. Trying to pass the finger around the mass showed that it was so extensive that removal was out of the question, though nobody present imagined that it was nearly as large as it afterwards proved to be. A small piece was therefore cut off for examination and the wound closed, a drainage-tube inserted, and an antiseptic dressing applied. The shock of the operation was severe, but the patient rallied for a time, and for twenty-four hours seemed to be doing well. On the second day, however, the heart's action began to fail, and death ensued painlessly forty-eight hours after the operation.

Autopsy, twelve hours after death, by Dr. Sawyer. Present, Dr. Ross, Dr. Conroy, Dr. Schemm, and others. Only the encephalon was examined. On removal of the calvaria the entire left half of the cavity seemed to be filled with the tumour, the surface of which resembled very strongly a normal hemisphere, being lobulated and fissured in such a manner that a superficial glance detected but little difference between it and the right hemisphere, which was macroscopically absolutely normal. The tumour was invested with a closely adhering tough fibrous membrane which sprang from the falx cerebri. There were no other attachments. On dividing this attachment and lifting the enormous mass out of the cavity the left hemisphere was seen lying on the base of the skull, flattened and compressed to the size and shape of the palm of a man's hand. Removing this and the right hemisphere, two smaller tumours were found on either side of the foramen magnum, attached to the dura of the medulla oblongata. The

main tumour weighed *one pound eleven ounces avoirdupois*. Its long diameter (antero-posterior) was *eight inches*, transverse diameter *three inches and a half*, and from surface to base *four inches*. Of the smaller tumours, one was of about the size of a plum, the other rather smaller. All three tumours were of very firm consistence and seemed homogeneous throughout. Several sections were made and examined microscopically by Dr. George C. Chase. They proved to be composed of pure fibrous tissue, with here and there a spot where the tumour was undergoing fatty degeneration.

I have reported this case at length from memory on account of the immense size of the tumour—the largest intracerebral neoplasm, I believe, on record—and because it affords an almost unique example of what the system will sometimes endure without collapse. Here was a young man with practically but half a brain, and that half pressed upon by its pathological neighbour, yet with heart and lungs perfectly normal, assimilation and excretion going on without interruption, and with even the mental faculties not seriously impaired; for the boy was intelligent, expressed himself well but for the mechanical difficulty of speech, and, until his sight failed, read much and with enjoyment. How long he would have lived but for the unfortunate operation it is impossible to say; but there was no sign of vital failure up to that time, notwithstanding the pressure upon the origins of all the left cranial nerves, including the pneumogastric. The accompanying block is taken from a photograph of the tumours reduced about one third.



To the best of my recollection we found no abnormality in the cerebellum, pons, or medulla. I cannot state from memory the details of the examination of the compressed hemisphere. Potassium iodide has been given in large doses without result.

CONTINENTAL PRACTICE.

HABITUAL EPISTAXIS.

By WILH. ROTH, M.D. (Vienna, Austria.)

Translated by DR. F. H. PRITCHARD.

It is contended by no one to-day that the term epistaxis has a very broad meaning, and that it may be due to the most varying causes. It has lost its place as a name for a clinically sharply outlined symptom-picture, and rather indicates a symptom which may appear under the most manifold pathological conditions. Habitual nose-bleeding is either caused by general diseases affecting the whole organism, or some change which affects the interior of the nose alone; and it is of importance to know this, for the results of profuse and repeated epistaxis are deleterious. The general diseases in which it may appear are:

1. Diseases of the blood vessels and of the blood itself, as in scurvy, morbus maculosus, werlhoffii, hemophilia, &c.
2. Great friability of the blood vessels in consequence of infectious diseases, acute exanthemas, typhoid fever, diphtheria, as well as in sub-acute and chronic infectious diseases, as malaria, pyemia, and septicemia.
3. All those diseases which lead to stasis of the circulation, as valvular heart disease, pulmonary diseases, tumours of the mediastinum, cirrhosis of the liver, Bright's disease, amyloid disease of the liver and kidneys, and finally, during the physiological process, pregnancy.
4. Vicarious menstruation, which, though not very frequent, is yet observed here and there.

Among the local changes in the nose are:

1. Erosions and superficial ulcers of the mucous membrane, which are chiefly found on the anterior portion of the cartilaginous septum, and arise from cartilaginous elevations, ecchondrosis, cristæ.

These are also found on the floor of the nose, though less frequently, as well as on the middle and lower turbinated bones. In many cases they are of traumatic origin—i. e., they are due to rubbing with the handkerchief or scratching with the finger-nail. In other cases they arise from the presence of a catarrh, and are dependent upon the erosive secretions or the action of pus.

2. Varicose enlargement of the veins upon the anterior section of the septum. In such cases, with light, one is able to see small bluish-red nodes on the cartilaginous septum from enlargement of the veins, which are very thickly interwoven here.

3. Perforating ulcer of the septum. This ulcer, which has been designated by Voltolini as *ulcus rodens*, is not of syphilitic origin. It may, as Hajek has demonstrated, begin on the mucous membrane, and, burrowing down, perforate even the cartilage and the mucous membrane on the other side, forming a perforation of varying size with sharp edges. As long as the edges of this opening are not healed over very profuse hæmorrhages are liable to take place.

4. Ulcerations of the mucous membrane and of the bone in consequence of syphilis, tuberculosis, lupus, and other destructive processes.

5. Neoplasms, among which are sarcomas and soft carcinomas, are especially prone to hæmorrhage. Fibrous or mucous polypi hardly ever give rise to epistaxis.

6. A certain friability of the mucous membrane, which microscopically presents no discoverable alteration.

7. Traumatism, as blows, a fall upon the nose, &c., with fracture of the bones or not.

The source of the hæmorrhage should be sought for—not at the moment when the bleeding is taking place, but later. Proceed to find the spot by touching the whole mucous membrane with the end of the nasal probe, and, on pressure, the seat of the lesion will be liable to become apparent, for though the healthy mucous membrane may bleed a drop or to the affected portion will spurt blood profusely. Cocaine should not be previously used, for it produces an artificial anæmia which may prevent the success of the experiment. Only profuse and sudden hæmorrhages are to be regarded as indicative of lesions. If this does not succeed, then the results of the treatment will possibly throw light on the case. In the treatment the hæmorrhage must be controlled, regardless of its source. A good way to stop it is to grasp the wings of the nose with the thumb and forefinger, and let the patient lean the head forwards. Thus a clot forms in the nose which prevents further hæmorrhage. Often a compression of several minutes is necessary. If this fail, pack the nostril with cotton and incline the head forwards. Apply cold to the back of the neck. The perchloride of iron is not advised, as it will irritate the mucous membrane, and is really no better than cotton alone. If this fail, do not waste time with injections of various remedies, but proceed at once to tamponade. Never use Bellocque's canula in such cases, as it is inconvenient, but introduce long strips of gauze wicking, pushed in, layer after layer, until the whole nostril is filled. Iodoform gauze is disagreeable on account of its odour, and has no advantage over other gauze or wicking. Leave it in for three days, when it should be removed, as it will begin to become septic and unnecessarily irritate the mucous membrane. Growths must be removed by the snare, curette, or caustics, or possibly all three. Tuberculous ulcerations are to be curetted thoroughly, with subsequent cauterisation. Syphilitic ulcerations demand general anti-syphilitic treatment, and touching the ulcer with a one per cent. solution of corrosive sublimate as long as it is not cleansed, and then, till healing, with a solution of iodine or nitrate of silver. In case of venous dilatation, excoriations, or a certain lesibility of the mucous membrane, energetic cauterisation with the galvano-cautery, chromic or trichloroacetic acid will form a firm cicatrix which will obliterate these conditions. Nitrate of silver does not form a scab which clings well, and hence is not adapted to cauterisation here. Trichloroacetic acid is of service in the milder forms, chromic acid forming a very tenacious eschar, and the galvano-cautery in the more severe cases, as they have a deeper action. Chromic acid is to be preferred, as it penetrates very deeply into the tissue, and leaves no scar, requiring three weeks to fall off. The galvano-cautery is liable to be followed by adhesion; treat afterwards with a solution of pyoktanin. Chromic and trichloroacetic acids cause no adhesions.—*Wiener Med. Presse*, Nos. 23-24, 1893.

AMERICAN OPINION.

SOME SUGGESTIONS IN THE TREATMENT OF PNEUMONIA.

By A. S. MADDOX, M.D.

[A Paper read before the State Medical Society of Western Virginia.]

A GREAT deal has been written concerning the treatment of pneumonia, but after a study of thirty-six cases in individuals whose ages range from two to eighty, some points have been observed which, although they are not new, may yet be worth mentioning again.

Unlike hospital cases, these were not treated and studied under the most favourable conditions, being distributed over a considerable area of country. I do not aim or expect to advance any new theories or something you have not all read about or used at some time or in some measure in your practice, nor do I wish to tire you with prolix details. But I do wish to reiterate with emphasis some essential if not cardinal points in the treatment of this disease, as well as to discourage and condemn some prevailing methods used by numerous physicians with whom I have come in contact either in consultation or conversation.

In twenty of the thirty-six cases referred to the disease in a general way was to be considered mild, as only one lobe was affected in either the right or left lung; yet in some of the cases the temperature ran as high as 105.5° F., and delirium was well marked. All of these cases were treated in almost a routine manner, with slight modification according to the severity of the symptoms.

Externally, counter-irritation was used with either a spice poultice or a mustard plaster over the side affected, and sponging the surface with cold or tepid water was resorted to in some of the cases of high temperature. In two, blisters of cantharidal collodion were used where resolution was delayed. Internal medication consisted chiefly in the use of carbonate of ammonium from onset to convalescence, and in most of the cases some quinine was given as a tonic throughout the entire course of the affection.

Latterly, as seemed necessary, alcoholic stimulants were administered. All these patients recovered. The remaining sixteen cases were of a more severe type, due to affection of more than one lobe in one lung, and in two cases crossed pneumonia existed. In all of these cases carbonate of ammonium was given throughout the whole course of the disease, and the severer symptoms were met by nitroglycerine and digitalis with very satisfactory results in all but two cases, which succumbed. One of the patients, who died in spite of all remedies, was a young man who had coexisting bronchitis following measles, and the other a man aged fifty-eight who had double pneumonia.

In these cases all remedies given seemed to make no impression. As before stated, I have used nitroglycerine considerably with happy results.

In those cases where a decided weakness of the first sound of the heart existed, and the pulse denoted a tendency to heart failure by being irregular or very quick and feeble, trinitrin was promptly administered in doses of from one-hundredth to one-fiftieth of a grain every fifteen minutes to one hour until the effect of the drug could be noted; this was followed by digitalis in doses of from ten to thirty minims every six to eight hours, at the same time continuing the former drug—*e.g.*, in one case—that of a man aged fifty-five, whose respirations were 55, pulse 125 per minute, and temperature 104.5° F.—nitroglycerine was given every fifteen minutes in one one-hundredth-grain doses, and in one hour respirations were reduced to 40, pulse 98, and temperature 103° F. This was followed by digitalis in thirty-minim doses, and the very dangerous condition due to enfeebled heart never returned. Subsequently, alcoholic stimulants were given in large quantities, and extract of malt was ordered by the dozen bottles. Although there was a very slow resolution, which extended over about two months, the patient recovered.

Having only given a glance at the cases, I will summarise the salient points I wish to emphasise.

In the first place, and as seems to me a very important factor in the treatment of these cases, no direct medicinal antipyretics were used, especially of the coal-tar series—a fact that should be particularly observed in the treatment of all diseases where there is likely to be great prostration and depression of the nervous system with a tendency to heart failure.

Some medical men whom I know, and who advocate the use of antipyrine, phenacetine, and acetanilide in pneumonia in the same conditions, have met with terrible disaster, and still continue to use the drugs in this disease.

I should like to urge upon members of this society (if there are any who use these remedies with the hope of reducing temperature) to discard them and substitute some good stimulant, such as we find in the carbonate of ammonium, throughout the course of the disease. Then sponge more and give fewer drugs. In lieu of these, push nourishment and stimulants even to a fault.

Many of the cases mentioned followed *la grippe* and were accompanied by great depression of the nervous system, and had it not been for sustaining measures, I have reason to believe many patients would have died. And now the lesson to be learned from a careful attempt to study these cases it seems to me can be summed up in a few words. That a rational conclusion is to maintain the patient regardless of reduction of temperature only as subsidiary means; to watch for any contingency which may arise and combat it as such; and lastly, but of paramount importance, is to not discourage the heart by tampering with any of the coal-tar derivatives.

UTERINE INERTIA.

TREATMENT WITHOUT DRUGS OR FORCES.

By C. C. VAN WATERS, M.D.

UTERINE INERTIA includes those cases of partial as well as complete inefficiency on the part of the uterus to expel its contents at the full term of gestation.

This condition may be due to a distended bladder or rectum, some sudden emotion, general debility, or great distention of the uterine cavity, as in dropsy of the amnion.

The customary practice of emptying the bladder and rectum not only removes an obstruction, but has a stimulating effect on the uterus, and may be all that is necessary to do in certain cases.

But in overdistention due to dropsy of the amnion I would first rupture the membranes, as is usual, and then wait a sufficient length of time for the water to drain away, and also for the muscular coat of the uterus to recover from the temporary paralysis to which pressure has subjected it. Again, we must wait in all cases for dilatation of the cervix to take place to a certain extent and some characteristic first-stage pains, so we may know that labour has begun.

Now, all these cases I would treat alike, when practicable, by stimulation. Not by oxytocics, however. The risk in giving these remedies to promote labour is well known, but will bear repeating as follows: Tonic and irregular contraction, thereby endangering the life of the child by prolonged pressure and consequent disturbance of the circulation. Laceration of possibly both cervix and perineum of the mother.

But as to the treatment: The beneficial action in constipation of the bowels of a suppository in the rectum is widely known. Why will not the same happy result obtain in uterine inertia from the use of a suppository in the vagina? And what more ready and effective suppository could we have than the hand?

Hence I would say, when the case has so far progressed that we are satisfied it is time for labour to take place and yet uterine inertia has supervened, render the hands thoroughly aseptic by the use of water, soap, and a brush, and afterwards a creolin solution. Then, having administered a little chloroform to the woman, thoroughly anoint the hand with vaseline and gradually and slowly introduce it into the vagina.

As soon as it has remained there a few moments pains will commence and increase in severity, in some cases to such an extent that you will soon have to withdraw your hand.

This, which may be termed the suppository method, need not possibly be required on the average in more than one case in five or six. But since it acts by stimulating the natural forces to simply normal activity, it is far better than the use of oxytocics or operative midwifery, and in the cases in which I have resorted to it the results have been gratifying.

DEAR SIR,—In the three cases of nervous depression in which I gave Pil. Aphrodisiaca (Lilly), I was pleased with the effect, and the patients, too, believed in their virtue.

W. WILLIAMS, M.B., M.R.C.S., L.S.A.,

Drim, Fishguard,
6th September, 1893.

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MEDICAL REPRINTS.

WITH ORIGINAL ESSAYS.

JANUARY 15th, 1894.

THE recent meeting of a "Pan-American" Medical Congress forced upon the notice of medical men the desirability, if not the necessity, of having one language to serve as a common means of communication between different countries. The official languages were four in number: French, Spanish, Portuguese, and English. Doubtless a goodly number in the Congress could understand two of these tongues; a smaller number may have been more or less familiar with three; but there were probably not a score among those present who could understand everything that was said in all of these official languages. Nor was this all. A Heidelberg professor who was invited to attend the Congress, published an open letter to the effect that neither he nor many of his colleagues would attend unless German were added to the list. Thereupon a rule was adopted making it allowable to speak in any language. If many of the invited guests availed themselves of this privilege the confusion of tongues must have been sorry indeed.

This question of a universal language for the convenience of scientists has often been discussed before learned societies in this country and elsewhere. If any one of the three tongues—French, German, and English—which are always the official languages at the international medical congresses, could be chosen, English would have the strongest claim, for that is the one spoken by the greatest number of people in the civilised world. According to an estimate of Mulhall, English is spoken by 111,100,000 people, while 75,200,000 speak German, and only 51,200,000 French. Forty years ago, indeed, Jacob Grimm, in his treatise on the origins of language, called English the world's language, and expressed his belief that it would prevail more and more extensively throughout all portions of the earth. Should national jealousies render the choice of any one of these three tongues impossible, we must look altogether further afield for a language that would be acceptable to all, and it is probable that one of the classical dead languages would be selected for the purpose.

Pending the only sensible and scientific ultimate conclu-

sion, and the one which is practically inevitable, probably no better solution of the *crux* will be found than in the use of either Latin or Greek. Even so, there will have to be a give-and-take agreement as to the pronunciation of whichever is adopted; and Professor Blackie would no doubt be heard from, as a kind of *amicus curiæ*, if Greek were favoured, in the sense of pronouncing that tongue by accent instead of, as we have most of us been accustomed to do, by quantity. Thus even when a dead language is decided upon, the struggle will not be over. As a temporary expedient Latin, pronounced in the Italian manner, would probably be the best choice. English is quite inevitable in the long run.

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NEWS AND NOTES.

WHILE Mr. Hubbard was United States Minister to Japan (writes a correspondent of the *Dental Journal*, Ohio), I visited that country and spent a pleasant week with him. One day I was troubled with toothache, and Mr. Hubbard took me to a dentist and explained to the saddle-coloured operator that I wanted the grinder extracted. I was placed in a bamboo chair and tilted slightly back. The dentist examined my teeth, talking volubly meanwhile to Uncle Sam's representative. Suddenly his thumb and forefinger closed on the troublesome tooth, and before I had the faintest idea of what was going to happen, he lifted it out and held it before me, smiling at the same time that vacant smile peculiar to the children of the Orient. "You were waiting for the forceps, were you not?" said Minister Hubbard with a laugh, "They don't use them here."

* * *

AND on the kindred subject of medicines in Japan, an *attaché* writes in the columns of another American contemporary:—Perhaps the most charming manner of compensating physicians for their care and attention is that which is customary among the natives of Japan. Physicians do not charge for their services, but, on the contrary, decline to name an amount, and protest against any idea of remuneration. Patients on their side are too proud to accept such services free, and send to the physician, not as a fee, but more as a friendly gift or token of gratitude, a sum of money proportionate to the means of the giver, with some piece of silk, brouze, or lacquer work—the idea being that medical attendance is by far of too important and elevated a character to be desecrated by filthy lucre. "What a pity," the commentator adds, "that our boasted Western civilisation, with all its commonplace vulgarity and lack of delicacy, will not admit of adoption of such a charming method between the medical man and his patients!" The real vulgarity is not where the correspondent of our contemporary supposes. It resides in the personality of the pretender who feigns to detect something too coarse for his supersensitive taste in the idea of a patient paying his just debt to a medical man. Such a scruple might be more reasonable if a spiritual function were in question, but we have not heard of any delicacy on the part of the clergy in the receipt of their stipends. The ridiculous affectation to which our contemporary gives its sanction is best ignored, as it is ignored by all sensible people, lay and professional.

* * *

La Médecine moderne recently gave an account, here briefly summarised, of a curious case reported in the Russian medical papers:—A girl, seventeen years old, was overtaken by night near the village of Ruzino, in the government of Moscow, on the 24th of November, 1892. Being afraid to go home in the dark, she decided to pass the night under a *hangar* covered with a little straw. During the night a snowstorm occurred, and in the morning the girl found herself unable to escape from the load of snow which covered her. The first day she ate five morsels of bread which she had with her. After that she had no other nourishment than the snow which imprisoned her. It was not until the end of fifty-one days that she was discovered under a bank of snow three feet and a half deep. She was then, on January 14, 1893, taken to a hospital. Although completely exhausted, and unable to move a limb, she could answer questions and was conscious of what was going on about her. Her skin was cold and pale, and there was general anasarca; the mucous membranes were of a striking pallor; no trace was left of the subcutaneous fat, and the muscles were wasted. Her voice was very feeble; her respiration was 26; her pulse was 84, small and weak; her temperature was 100.4° F. The heart sounds were distinct but feeble, and an anæmic souffle was audible in the vessels of the neck; the urine was concentrated, but contained neither sugar nor albumen. For two days she remained in a state of semi-unconsciousness and somnolence, but she made rapid progress, and at the end of the first week she could take the ordinary diet of the hospital. If we suppose that the date of her imprisonment in the snow was correctly stated, and that she ate all the bread on the first day, the account goes on to say, this involuntary imitator of the redoubtable Succi must have gone from the 24th of November to the 14th of January, exactly fifty days, without taking any nourishment.

* * *

COMMENTING on the statement which has been going the rounds of the pharmaceutical papers in America, to the effect

that "There are at least one hundred new remedies of synthetic origin now in general use, that were not known ten years ago," the *Chemist and Druggist* observed some months ago, "We doubt if anyone can compile a list of one hundred. Who will try?" The challenge has been taken up.

"We are not responsible for the original statement, but the invitation is general, and we are anxious that our English friend should have a prompt response from America, so here goes," says the editor of *Notes on New Remedies*: "Acetanilid, agathin, alpha-oxynaphthoic acid, alumol, amylenhydrate, analgen, antipyrine, antiseptol, antispasmin, antithermin, aristol, asaprol, aseptin, benzanilid, benzonaphthol, benzozol, betol, bromal-hydrate, bromoform, bromol, chinoline, chloral-amid, chloral-ammonium, chloralose, chlorphenol, creolin, cresalol, cresin, cresol, cresol-iodide, cresotic acid, diuretin, dulcin, ethyl bromide, ethyl chloride, eugenol, eugenol-acetamid, euphorin, euphorin, exalgine, formalin, formanilid, galla, cetophenone, gallo-bromol, gallol, guaiacol, guaiacol-carbonate, homatropine, hydracetine, hydroquinone, hypnal, hypnone, ichthyol, iodol, iodopyrine, kairin, losophan, lysol, metaldehyde, methacetine, methylal, methyl, chloride, methylene-blue, methylene chloride, methyl-violet, microcidine, naphthalene, naphthol, naphthopyrin, orexine, oxychinaseptol, paraldehyde, pental, phenacetine, phenetol, phenocoll, piperazine, pyridine, resorcin, resorcinol, saccharin, salacetyl, salicylamide, saliphen, salipyrin, salocoll, salol, salophen, saprol, solutol, solveol, sozal, sozoiodol, styracal, sulphaldehyde, sulphaminol, sulphonal, tetronal, thalline, thermifugin, thilalan, thioform, thiol, thio-phen, thioresorcin, thiosinamin, thymacetin, tolypyrin, tolusal, tribromphenol, trional, tumenol, uralum, urethane." This is truly a portentous list, but are all these esoteric drugs really described with accuracy by the term "synthetic"? It appears to us that some, at least, among them are not of such origin as to place them in that category.

* * *

DR. S. ZICHY-WOJNARSKI reports in the October number of the *Australasian Medical Gazette* a case of measles followed by fatal uræmia. He speaks of the extreme rarity of fatal uræmia as a complication or sequel of measles, but states that two other cases have occurred during a late epidemic of measles in Ballarat. One was in a girl six years old. The renal condition was diagnosed as one of acute desquamative nephritis, and the author asks if it might not be that in this case the morbid matter expended most of its violence on the hypoblastic tissues in place of the epiblastic, the ordinary field of its intense action.

* * *

THE Superior Court of New York has ruled that when a married woman is so injured through the negligence of another person as to miscarry, her husband can recover damages for the loss of the child. In the case on trial the damage was assessed by the jury at some £450! Suppose the expected infant to have had a fair chance of weighing eight pounds at birth, this means consolation to the disappointed parents at the rate of about seventy shillings an ounce, a goodly sum, and one which comes very near to the proverbial "worth his weight in gold."

* * *

A NEW YORK physician has given currency to some statistics said to have been compiled by a former patient, whom he had turned over to the care of a surgeon for operative treatment of tuberculous glands of the neck. Asking, in way of friendly interest how his former charge was progressing, he received (he says—but there are jokers, and even medical jokers, in America) the following document:—

"*Account of Myself up to October 29th, 1893.*—Operated on May 10th, October 16th, 1890, and April 1st, 1891. Have had 87 enlargements up to now and 66 suppurating openings. Have now 27 openings suppurating—6 in neck and throat, 6 in chest, 7 in back between waist and shoulder blade, 2 in thumb joint, 1 in right armpit, 3 in left armpit, 1 in left side five inches below armpit, 1 in right side five inches below armpit. No less than 160 quarts of pus have come from me. Have used no less than 6,000 yards bandages, 15 yards of court plaster, 2 yards of oil-silk, 100 pounds of flaxseed, 20 pounds of absorbent cotton, 6 pounds of vaseline, 1 pound of salve, 1 pound of oakum, 2 pounds of liquorice powder and salts, 1 ounce of aris-ol, 4 ounces of iodoform, 600 pills, mostly sulphide calcium, 10 plasters, 1 caustic pencil, 70 quarts inward medicine, 2 quarts peroxide hydrogen, 2 quarts carbolic acid, 12 quarts liquor (what liquor?), 1 pint iodine, half-pint balsam Peru, 4 syringes. This does not reach the figure at all. Yet it is enough to convince the most morbid. I hope to get well yet."

ON CONVALESCENCE FROM FRACTURES.

By GEORGE W. KING, M.D., Surgeon to the Montana Mining Co., Limited.

AUTHORITIES lay but little stress upon this most important period in the treatment of fractures. The proper reduction and retention of the fragments of a broken bone is considered the principal thing to insist upon. The fear of shortening or angular deformity has no doubt been re-sponsible for many imperfect recoveries. It has prompted too long continued immobilisation with resulting loss of function that in many cases is never wholly regained.

We are told in detail how bones unite, how special fractures should be treated, the length of time required for union to take place, &c. If these were all the facts to be considered we might with propriety omit any further investigation of this subject. Unfortunately, such is not the case, and we must continue our efforts to perfect the methods at hand.

The many conditions and influences that may hasten union of bone, such as age, location of fracture, ability of reduction and retention, general condition, and previous habits of the patient, are well known, and preclude the possibility of any definite rule for guidance as to the length of time immobilisation should be employed. Each case must be left to the judgment of the attendant.

Many surgeons, doubtless the majority, are inclined to assume that their duties are ended upon the removal of the retention apparatus. This is certainly a dangerous practice, and cannot be recommended in any case. Numerous instances have occurred under my own observation where an excellent result has been compromised by want of care after removal of the splints and bandages.

The production of curves that Nature never intended is neither creditable to the surgeon nor useful to the patient.

We can only avoid such unpleasant complications by familiarising ourselves with the different stages in the progress of recovery. No difference of opinion exists among surgeons as to the advisability of immobilisation in all traumatic ruptures of bone. No exception is made in cases where there is not displacement at the time of injury. Common prudence suggests this course as a preventive measure, for no one can tell what harm movements of the patient or muscular contraction may do.

Practically, then, we have to deal with the effects of immobilisation during the convalescence in every case of fracture. The number of cases presenting themselves to the surgeon to obtain relief by operation months, even years, after the injury, is greater than physicians who do not undertake surgical cases are aware of—far greater, indeed, than it should be. Much better results are possible if we choose to adopt methods based upon a thorough knowledge of the processes involved in the healing of fractures.

The condition of a limb after being immobilised for several weeks is one of complete helplessness. The appearance is more or less characteristic, the whole limb shrunken, the muscles lax and without resistance, the skin smooth and glossy.

Muscular atrophy is nearly constant, though varying in degree; it is not limited to the injured part, but extends to the superior and inferior portions of the limb.

Recovery from this condition is very slow. Cases have been cited in which, some years after, there still existed a marked degree of difference in size between the healthy and injured limb. The pathology of muscular degeneration subsequent to fracture is not positively known. Whether compression and immobilisation are alone responsible for it requires further proof.

A sufficient number of experiments upon healthy limbs ought to demonstrate how much is due to this cause. I am not aware of any particular evidence in this connection, aside from that furnished by cases of fractured femur, in which both limbs are included in the immobilisation apparatus. It is stated upon good authority that the atrophy is greatest in the injured limb.

Increased nutrition incident upon the formation of the callus is thought by some to impair the general nutrition of the limb. Observation and experience fail to sustain this theory. Contusion of nerve filaments, inducing neuritis, has been named as a cause. Whatever may be the true pathology, it is evident that disuse of a limb is an important factor in producing loss of function. We know that muscles deprived of their normal stimuli are poorly nourished, and degeneration of their fibres takes place.

Other changes to be mentioned relate to the venous circulation in the injured part; to these are due some of the dis-

agreeable symptoms occurring at this time, notably the cedema that usually persists for an indefinite time and becomes troublesome when the limb is recumbent. To what is this abnormal condition of the circulation due?

Can we explain it by the vasa-motor theory, or consider it purely mechanical? At the seat of the injury there must necessarily be extensive rupture of the veins, which would naturally affect the return current through the part. Probably many of the smaller veins are obliterated, in some instances by pressure, in others by thrombi that effectually obstruct the vessels. In consequence of this mechanical interference, swelling occurs, and persists until collateral circulation has become sufficiently established to empty the vessels. Perhaps the complication most to be dreaded in the secondary stage is that of stiffness of the joints in the vicinity of the fracture. Much of the disability in the early convalescence is due to this cause; the tendons no longer glide smoothly as in health, the limited amount of motion is painful in the extreme, and the joint, like a rusty hinge, is unfit for service until its freedom of motion is restored.

How shall we treat these conditions? It is not sufficient to tell the patient to use the limb, for, when he attempts to follow this advice, he is quickly made aware of its weakness. Every movement is painful, and he is for this reason more apt to desist from his efforts than to persevere, and therefore is too willing to trust to time to work a cure. We know such reasoning is fallacious, as we have seen; there must be a restoration of the circulation to nourish the part, the muscles must be stimulated to action, and the joints freed, before we can hope for any progress towards recovery. It is therefore a very unwise procedure to trust this important period to the patient himself. It is at this time that we are able to do more toward restoring the normal functions than at any subsequent time. Experience teaches us that these cases are especially liable to become obstinate after several months have elapsed. There remains to consider what measures to adopt whereby we may avoid the many complications, or at least reduce them to a minimum. The indications are plain enough, and have already been shown in referring to the effects of immobilisation. From careful investigation, I am led to believe that massage promises the best results in the conditions named. By massage I do not mean the promiscuous rubbing usually indulged in, nor the rough, clumsy manipulations that endanger the continuity of the partially formed callus, but the light, skilful touch of the "masseur" applied scientifically. Of course, it is unreasonable to suppose that physicians are ordinarily masters of this art, yet enough of the science ought to be acquired with but little trouble to carry out the treatment here advised. The advocates of the massage treatment of fractures without immobilisation claim good results—equal if not superior to that obtained by the time-honoured custom by splints, extensions, &c.

They bring to their aid in proof of the correctness of their views examples furnished by the history of fractures among animals, where immobilisation is impossible, and yet union takes place. Admitting this to be true, I imagine few of us would care to take the risk of treating fractures without employing some retaining device until the danger of displacement had passed.

When shall we begin the use of massage?

At the very earliest moment that it can be done without causing displacement. A judicious selection of a retention apparatus that will allow free access to the limb without removal of the entire dressing is an advantage, particularly at the beginning of treatment. My preference is for the plaster-of-Paris splint, for it can be readily opened and closed without deranging the fragments. By this plan we shall be able to not only combat successfully the degenerative changes in the muscles, but to keep the circulation in its proper course, thereby aiding the rapid absorption of excessive effusion that so frequently delays the normal process of healing. The same treatment applied to the joints keeps them pliable and ready for use when the time comes to resume their functions. With the nutrition of the limb provided for, the articulations guarded against abnormal conditions, we shall have done our part towards insuring results of which we need not be ashamed.

THE MENOPAUSE AND ITS NEUROSES.

DR. GUSTAVUS ELIOT, of Newhaven, contributes to the September number of *The American Journal of the Medical Sciences* an article entitled "The Disorders of the Nervous System associated with the Change of Life." After mentioning women's habitual disregard of their health in their

earlier life, and the frequency of occurrences calculated to beget emotional disturbances between the fortieth and fiftieth years of age, he says :

"If you inquire carefully in regard to the clinical history of one of these patients, you will find that she suffers from more or less of the following symptoms : Indisposition for exertion, inability to work, forgetfulness, headache, dizziness, insomnia, flushes of heat followed by chilly sensations, sweating, palpitation, flatulence, abdominal distention, and constipation. On making further examination, you will probably find that her heart and lungs show no evidence of any organic lesion, and that her flesh is flabby, her pulse soft, her tongue coated, and the conjunctivæ are pale. She may have considerable intercostal neuralgia and frequent backaches, and tender spots may be detected in her head, back, and chest. She also sometimes complains of swelling of the face, hands, and feet, which, however, is often not a real oedema.

"A study of the clinical history of these cases, and a consideration of the inconstant and changeable character of the symptoms, is sufficient to convince one that they are not of organic origin ; that they are not associated with any distinct pathological change in the nervous system, but that, on the other hand, they may occur in connection with a variety of different conditions.

"In some cases a disordered digestion is the most important factor in the causation and perpetuation of these very distressing symptoms. The chief disturbance may be in the stomach. The eructations of gas and flatulent distention of the stomach are frequently the most annoying and most important symptoms. Or, on the other hand, the intestines and the associated glands may be chiefly at fault, and the most marked symptoms, obstinate constipation and flatulent distention of the abdomen. Not infrequently these two conditions are found co-existing in the same case. They may then give rise to or be associated with a number of other symptoms, the most common of which are headache, dizziness, palpitation, and dyspnoea.

"In some cases anæmia is an important element. This may be associated with disturbances of digestion, either as cause or effect. If both exist, each may intensify and aggravate the other. If anæmia is present, the patient usually complains of headache, dizziness, and dyspnoea.

"In other cases insomnia is a prominent feature. This also may be a result of pre-existing derangements of function of various organs, and in turn, when present, may aggravate other disorders.

"Finally, in many cases there is a distinct and well-marked element of nervous exhaustion. This is frequently the starting point of other disorders, and when they are fairly established is intensified by them.

"In making the diagnosis of this condition one should be very careful to exclude the possibility of the existence of any organic disease. In many cases organic diseases are accompanied by symptoms which resemble those which have been described as of frequent occurrence in connection with those functional disorders of the nervous system which are the subject of this paper.

"Careful exploration must be made of the chest—of the lungs, but more particularly of the heart, to which many patients think that their troubles are referable—in order to detect the possible presence of commencing or latent organic disease. Careful analysis of the urine should be made occasionally, in order that no organic change in the kidneys may escape notice. The temperature should be taken now and then, especially if the action of the heart is at all accelerated, so that no febrile disturbance may be overlooked. Naturally inquiry should be made as to the manner in which each organ of the body is performing its functions, and any deviation from the normal must be carefully noted and duly considered in deciding upon a plan of treatment.

"The prognosis of these disorders is rather uncertain on account of the variety of circumstances which influence their progress. Many patients are exceedingly dilatory in seeking medical advice for these troubles. Many are very negligent about following up the treatment which is prescribed, and some fail to receive proper treatment because their physicians make an erroneous diagnosis, or do not understand what therapeutic measures are adapted to the case.

"The natural tendency of these disorders is to persist for months and years. They do not, however, have any inherent tendency to terminate in death. With proper treatment their severity may be mitigated and their duration very much abbreviated. If the patient seeks advice early, is judiciously managed, and follows up the treatment conscientiously and persistently, the prognosis is good. Care must be exercised to remove, as far as possible, the conditions which permitted the

development of the symptoms in the first place, lest they return again after treatment has been discontinued.

"In the management of these cases it is necessary to combine very careful hygienic regimen with appropriate medicinal treatment. Worry and care must be avoided as far as possible. Regular and prolonged rest must be secured. A moderate amount of mental occupation during waking hours is useful. Abundance of fresh air and moderate exercise are essential. Food which can be easily digested and which has been properly prepared must be taken regularly and in sufficient quantity. It must be eaten slowly and chewed thoroughly, and time must be allowed for the process of digestion to become fairly established before the resumption of mental or physical exertion. Tea and coffee must be entirely abandoned, and abundance of milk and water must be taken. Bathing and rubbing influence very favourably the circulation and the processes of nutrition. The body must be properly protected, so as to maintain an equable degree of warmth throughout, care being taken to avoid the extremes of an excess or a deficiency of clothing.

"If the functions of any organ are not properly performed, the treatment must be so directed as to restore and maintain the normal action.

"The digestive organs are perhaps more frequently deranged than any others, and require most careful attention to secure a proper performance of their functions. Constipation, flatulence, and anorexia are the most common and the most important indications for treatment. If constipation exists alone, a pill of aloes and myrrh taken at night, and followed, if necessary, by another in the morning, will generally produce a pleasant effect. Another excellent pill under these circumstances is one containing one-fifth grain of aloin and one-sixtieth grain of sulphate of strychnine. Two or three of these may be taken at different times through the day, if one at night is not sufficient. The object to be aimed at is to secure one easy movement of the bowels each day, unaccompanied by nausea or griping, by means of small doses, repeated if necessary, of some not very irritating laxative.

"If anorexia, constipation, and flatulence are all present, a bitter mixture will generally prove useful—a combination of nux vomica, cascara sagrada, cardamom, and gentian, with aromatics, is exceedingly valuable under these circumstances.

"If anæmia is well marked, iron and arsenic are very useful. If there is no, or only slight, disturbance of the digestion, pills containing sulphate of iron with carbonate of potash, known as Bland's pills, with the addition of arsenious acid, produce excellent results.

"If constipation accompanies anæmia, a pill or capsule containing arsenious acid, aloes, nux vomica, and reduced iron may be advantageously prescribed.

"If neuralgia is a prominent symptom, five-drop doses of fluid extract of gelsemium will give relief in many cases. In connection with gelsemium, or in place of it, benefit will often be obtained from the use of sulphate of quinine with extract of hyoscyamus.

"If the nervous symptoms are not accompanied by derangement of the functions of other organs, or if they persist after proper attention has been paid to the regulation of these disorders, it is necessary to prescribe remedies which act more directly upon the nervous system. The most useful drugs of this class are bromide of sodium, phosphorus and its compounds, nux vomica, and arsenic.

"The use of arsenic has been already mentioned in connection with the management of cases in which anæmia is an important factor. In the treatment of certain forms of anæmia it is of great value. But besides increasing the production of red blood cells, it unquestionably possesses the power, also, of promoting the nutrition and vigour of the nervous system. In combination with iron and nux vomica it is exceedingly useful.

"The utility of phosphorus as a nerve tonic has long been recognised. A combination in pill form of one one-hundredth grain of phosphorus with one quarter grain of extract of nux vomica, has been used extensively and with excellent effect. One great drawback to its use is the difficulty of securing pills which have been properly made, and in which the original characteristics of the drugs have been retained.

"Phosphide of zinc is frequently substituted for phosphorus. One-tenth grain of this compound with one-fourth grain of extract of nux vomica will often prove of benefit.

"The compound syrup of the hypophosphites is another preparation which is very popular with the profession, and which has positive value as a nerve tonic.

"As a palliative agent, to produce sleep, to equalise the circulation, and to relieve the condition of nervous irritability commonly called nervousness, no drug is more useful than

bromide of sodium. This salt is preferable to the other bromides because it is less unpleasant to take, and is less irritating to the stomach, while at the same time it is not inferior in therapeutic value. In prescribing this very valuable drug, one should never forget that it does not increase the strength or nutrition of the nervous system. It should not, therefore, be relied upon for continuous prolonged administration to the exclusion of other remedies. On the contrary, its use should be supplemented by the administration of general tonics and of special nerve tonics. Iron and arsenic are especially well adapted for this purpose.

"In conclusion, the following propositions are presented :

"1. At the time of life when the menopause occurs, the various organs of a woman's body are likely to be in a state of depression as regards either their nutrition or functional activity, so that the normal equilibrium of healthy action may be easily disturbed, and abnormal action, the manifestation of disordered function, may be inaugurated and perpetuated.

"2. The cessation of menstruation is an event of great physiological importance, and is perfectly competent to produce grave disturbances of the nervous system, if any predisposition to them already exists.

"3. The more common disorders of the nervous system occurring under these circumstances are functional in character, and are associated with disturbances of functions of other organs, and especially of the digestive, circulatory, and hæmatopoietic systems.

"4. In their treatment, attention should first be paid to improving the general nutrition of all the tissues of the body, and restoring each organ to its normal activity.

"5. If, after all the other organs have resumed the proper performance of their functions, symptoms referable to a disordered condition of the nervous system still persist, recourse must be had to remedies which act directly upon the nervous system, either by improving its nutrition or by modifying and regulating its action."

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

IRON SUBCUTANEOUSLY IN CHLOROSIS.—Prof. Rummo (*Muenchener Medicinische Wochenschrift*, No. 36, 1893) has experimented with various preparations of iron, &c., subcutaneously, in chlorosis, and finds the citrate of iron and ammonia to give the best results. The number of blood corpuscles and the amount of hemoglobin rapidly increased. The first symptoms of improvement were noticed after four or five injections, especially were the gastric symptoms and headache the first to disappear. The injections were made under all antiseptic precautions in the interscapular region, and never caused either swelling, redness, nor was albuminuria ever observed. The improvement was lasting. In five days the spleen was enlarged.

ANTISEPTIC TREATMENT OF OZENA.—The following treatment of ozena is recommended in *The Deutsche Medicinische Wochenschrift*, No. 36, 1893) : Douche the nasal cavity, first, with a solution of carbolic acid. Then insufflate the following powder :

R	Salol	...	...	...	...	3 ijss.
	Boric acid	...	...	...	...	3 j.
	Salicylic acid	...	...	...	...	grs. xv.
	Powdered talc	...	...	...	...	3 v.

Or the following powdered :

R	Muriate of cocaine	...	...	...	...	grs. jss.
	Menthol...	...	...	...	...	grs. v.
	Boric acid	...	...	...	...	grs. xxx.
	Finely powdered coffee	...	...	...	...	xv.

A pinch several times a day.

NEW REAGENT FOR ALBUMEN IN THE URINE.—Dr. E. Spiegler has improved his formula for the testing for albumen in the urine. It consists of the following :—

R	Sublimate	...	...	...	...	3 ij.
	Tartaric acid	...	...	...	...	3 j.
	Distilled water...	...	...	...	...	3 vjss.
	Pure glycerine	...	...	...	...	3 v.

CHRONIC DYSENTERY.—Half a tumblerful of a two per cent. solution of lactic acid twice daily, gave good results after other means had failed.—*Lojkin*.

NON-BITTER QUININE.—

R	Quinina sulph.	...	...	...	...	gr. xv.
	Acid. sulph. dil.	...	...	...	...	℥ xv.
	Spr. menth. pip.	...	...	...	...	3 ijss.
	Sol. saccharin saturat	...	...	...	...	3 v.
	Aquæ dest.	...	...	...	...	3 vj.

—*Medical News*.

FOR MEGRIM.—

R	Extracti cannabis indicæ	...	...	...	...	...
	Quinina sulphatis	...	...	...	...	aa gr. j.
	Perri arseniatis	...	...	...	...	gr. 1/10
	Extracti nucis vomicæ	...	...	...	...	gr. 1/2
	Misce et fiat pilula.	...	...	...	...	...

One to be taken twice a day.

—*The Practitioner*.

CHLOROFORM AS A TAPE-WORM REMEDY.—Dr. Stephen (*La Semaine Medicale*, No. 54, 1893) speaks highly of the value of chloroform in the treatment of tape-worm. With it he has succeeded in expelling worms where the usual tænicides failed him. He used the following, Thompson's formula :—

R	Pure chloroform	...	...	...	...	3 j.
	Simple syrup	...	...	...	...	3 j.

To be taken in four doses, at seven, nine, and eleven o'clock in the morning, and at one in the afternoon. At noon the patient is to take an ounce of castor-oil. It is well borne even in children.

CHRONIC TONSILITIS.—

R	Acid. tannic	...	...	...	...	gr. xv.
	Tinct. iodinii.	...	...	...	...	gtt. ij.
	Aquæ	...	...	...	...	3 vj.
	Glycerine	...	...	...	...	3 ss.

M. Sig. :—Tablespoonful every three hours.

ASTHMA.—

R	Ether	...	...	...	...	3 j.
	Oil of turpentine	...	...	...	...	3 iv.
	Benzoic acid	...	...	...	...	3 iv.
	Balsam of tolu	...	...	...	...	3 ij.

To be inhaled during an asthmatic attack.

FOR PITYRIASIS RUBRA.—

R	Zinci oxidi	...	...	...	...	3 j.
	Calamina	...	...	...	...	3 ss.
	Olei amygdalæ	...	...	...	...	3 vj.
	Olei deelinæ	...	...	...	...	3 ij.
	Aquæ	...	...	...	...	3 j.

Misce et fiat applicatio.

—*The Practitioner*.

AN EXCELLENT PILL FOR CHRONIC CONSTIPATION.—

R	Aloina	...	...	...	...	gr. viij.
	Strychnina sulph.	...	...	...	...	gr. ss.
	Ext. belladonna	...	...	...	...	gr. iij.
	Pulv. ipecac.	...	...	...	...	gr. xij.

Mix and divide into twenty-four pills, one nightly.

RECENT CORYZA.—

R	Morphine hydrochlorate	...	...	...	...	gr. ij.
	Pulv. acacia	...	...	...	...	3 ij.
	Bismuth subnitrate	...	...	...	...	3 vj.

Use as snuff.

FOR CHRONIC RHEUMATISM.—

R	Olei terebinthinæ	...	...	...	...	3 j.
	Linimenti camphoræ compositi	...	...	...	...	3 ij.
	Linimenti saponis	...	...	...	...	ad 3 vj.
	Misce et fiat linimentum.	...	...	...	...	...

To be well rubbed in to the painful parts three times daily.

—*The Practitioner*.

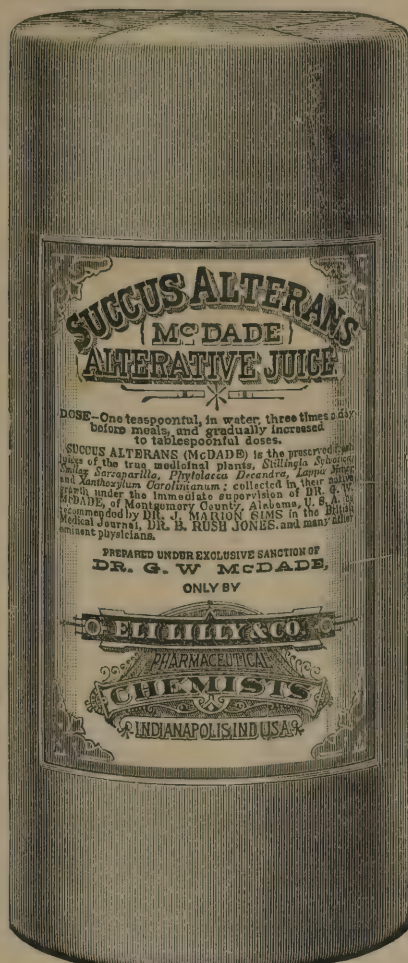
FOR HÆMOPTYSIS.—

R	Quinina hydrochloratis,	...	...	...	...	...
	Pulveris digitalis	...	...	...	...	aa gr. j.
	Pulveris opii	gr. ss.
	Misce et fiat pilula.

One to taken every six hours.

—*The Practitioner*.

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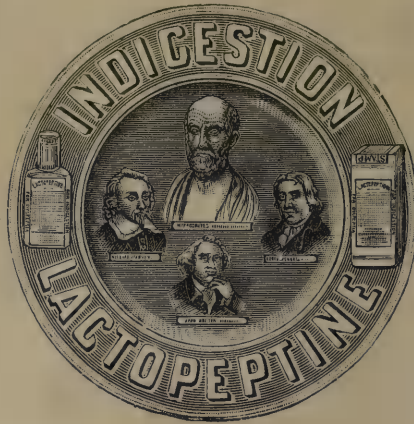
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The Medical Times and Gazette.—Where we have had an opportunity of presenting it, its employment has been decidedly satisfactory.

The Medical Press and Circular.—Such a formula is a desideratum, considering that the preparations of Pepsin now in use have disappointed the expectations of many practitioners.

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